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Negative Change in Psychotherapy

Section A: Negative change in psychotherapy: A review of
the literature

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Section B: A variable picture: A grounded theory analysis of
the experience of therapy in the context of negative change

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Salomons Centre for Applied Psychology
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Summary of MRP

Section A

This review identified 22 studies and articles which discussed the process of negative change following psychotherapy. Support was found for some correlates identified by previous reviews; interpersonal problems, initial high symptom severity, less favourable social characteristics, comorbidity and low levels of social support. Greater therapist inexperience, longer-term therapy or therapy which is terminated abruptly may also be implicated. Outcome measures alerting therapists to negative change and Clinical Support Tools advising how to respond may be helpful to reduce its occurrence. However, further research is needed; in particular qualitative studies, controlled trials and single-case methodologies.

Section B

This study generated a grounded theory of negative change by interviewing clients and therapists about the experience of therapy when negative change had occurred. Twelve participants were interviewed and the emerging model identified three main themes which helped to explain their experience; Therapy in the context of adversity, negative change related to the therapeutic process and help withdrawn. Findings highlighted the importance of paying attention to context and life events in negative change. Many clients wanted further input and some did not think there had been a negative outcome. Varied process issues highlighted the need to adjust interventions to fit clients.

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Major Research Project

Section A:

**Negative change in psychotherapy: A review of
the literature**

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Abstract

Objectives

This review aimed to establish current knowledge about the process of negative change following psychotherapy; whereby clients experience an increase rather than a decrease in symptoms according to outcome measures. It explored factors which might correlate with negative change alongside potential interventions and implications for practice and research.

Methods

Twenty-two studies were identified from systematic searches of Ovid Medline, Psycinfo, Web of Science and Cochrane Reviews databases. Quality assessment tools were used to aid in critiquing the studies identified. Findings were discussed in terms of conclusions and implications.

Results

A range of studies and articles were identified. Support was found for some correlates identified by previous reviews; having more interpersonal problems, initial high symptom severity, less favourable social characteristics, comorbidity and low levels of social support. Greater therapist inexperience, longer-term therapy or therapy which is terminated abruptly may also be implicated. Outcome measure which alert therapists to negative change and general feedback could be helpful to reduce its occurrence. Clinical Support Tools advising therapists how to respond may also be helpful.

Conclusions

There are few recent studies looking at correlates of negative change. Further research could help us know more about this phenomenon and reduce its occurrence.

Key words: Negative change, deterioration, psychotherapy outcomes

Introduction

Although there is evidence to suggest that psychotherapy is effective (Lambert & Ogles, 2004), there is also evidence suggesting that a small proportion of clients appear to leave feeling worse (Lambert, Bergin & Collins, 1977; Barlow, 2010). Despite this, a recent meta-analysis found that just 15% of RCTs measuring psychological therapy outcomes mention that negative change has occurred (Jonsson, Alaie, Parling, & Arnberg, 2014) risking a reporting bias and missing opportunities to improve therapies or avoid potential harm. Current estimates of the prevalence of negative change are around 3-15% of patients (Linden, 2013). However, compared with research on treatment efficacy, there is little focus on negative change in the therapeutic literature. This introduction will present the history around this phenomenon, followed by definitions and summaries of previous reviews.

Historical overview

Whilst the first observation of therapy-induced deterioration was recorded by Masserman and Carmichael (1938); debate around this issue began in 1952, when Eysenck reviewed the outcome research and concluded there was no evidence that psychotherapy “facilitates recovery from neurotic disorder” (Eysenck, 1952, p. 662). This was controversial and hotly disputed amongst therapists. In response, Bergin (1963) conducted a review attempting to explain why psychotherapy showed such modest improvements, finding that very few studies recorded adequate pre and post measures whilst controlling for differences between treatment and control groups. His review included six eligible studies and found a greater variability in outcomes within treatment groups as compared to controls, so that whilst some receiving therapy improved, others showed marked deterioration. This led therapists to think more about negative change and the risk that clients could be harmed as a result of therapy

(Barlow, 2010). Future studies sought to explain negative change, to measure it and to use this knowledge to prevent it.

Definitions

For the purposes of this review, negative change is defined as a process occurring during therapy, where a client's experienced symptoms of distress appear to increase or worsen. This is usually established by comparing outcome measure scores from treatment outset to termination or follow-up. To establish whether negative change is more than would be expected by chance and is clinically meaningful researchers have sometimes used calculations based on Jacobson and Truax's (1991) descriptions of reliable and clinically significant change. Clinically significant change is described as a return to 'normal functioning', where a client's level of functioning falls outside the range of the 'dysfunctional population', defined as two standard deviations from the 'dysfunctional' mean following treatment. They should also fall within the normal population range, or be closer to the mean of the functional range than the dysfunctional range. Deterioration, another term frequently used in the literature, would therefore entail being two standard deviations from the functional mean or closer to the dysfunctional than the functional mean. The reliable change index (RCI; Jacobson et al, 1984) sets out to establish that change is not due to measurement error and uses the following calculation;

$$\frac{\text{Pre-test score} - \text{post-test score}}{\text{Standard error of differences}}$$

Where the RCI is greater than 1.96, this indicates that there has been reliable change.

Researchers often consider a movement of two standard deviations on an outcome measure score to represent a significant change in either direction.

Previous Reviews

Lambert, Bergin and Collins (1977) Therapist induced deterioration in psychotherapy

This chapter reviews 48 studies describing the occurrence of 'client deterioration'. It includes studies discussed in Bergin's (1963) review and additional research up to 1975, providing a thorough critique of studies described and selecting key studies which provide evidence about mechanisms which might underlie negative change (Lieberman, Yalom & Miles, 1973; Ricks, 1974; Sloane, Staples, Cristol, Yorkston & Whipple, 1975). Specific patient and therapist characteristics and the interaction of these, thought to be linked to deterioration, are discussed.

In terms of patient characteristics, the authors describe those diagnosed as 'schizophrenic and psychotic' as being susceptible, stating that the history or duration of the disorder may play a role. This is based on research comparing deterioration across diagnostic category (Fairweather et al, 1960) and the postulation that deterioration may occur in the opposite form to spontaneous remission (Rachman, 1973). They state that, for example, depression may have the lowest rate of deterioration since it has a higher rate of spontaneous remission than say, hypochondriasis. Other patient characteristics come from the Lieberman, Yalom and Miles (1973) study of encounter groups. They found that low levels of self-esteem, greater involvement with the group, higher growth orientation and greater anticipation of need were positively related to deterioration. The authors then cite articles discussing poor outcome in psychoanalysis (Kernberg, 1973; Horwitz, 1974) stating that 'low quality of interpersonal relationships', low tolerance of anxiety or frustration, low motivation, Borderline Personality organisations and 'predominant oral fixations' are client characteristics which may be contraindications for treatment.

The authors then discuss therapist factors which might be linked to deterioration. Firstly, a study by Whitehorn and Betz (1960) investigating therapists with low success rates is reviewed, under the assumption that better outcomes could be expected (the authors used a broad definition of negative change). They found that therapists who viewed the client as wayward and needing correction, who were rigid and expected deference were likely to achieve low success rates. Secondly, a study by Vandebos and Karon (1971) links negative outcomes to ‘pathogenic therapists’, described as clinicians using therapy to satisfy their own needs as opposed to the patient’s. However, case examples describing therapist behaviour are extreme, raising questions about the relevance of these findings some 45 years later. Particularly considering increased regulations around therapy, guidelines around supervision and the prevalence of Cognitive-Behavioural models, in contrast with examples given, which appeared to describe psychoanalysis as provided by psychiatrists. Thirdly, the authors discuss therapist level of experience, suggesting that inexperience may play a role in deterioration, despite mixed findings in this regard. Finally, they discuss therapist personality, again looking to Yalom and Lieberman (1971) who identified 7 types of group leader, finding that ‘aggressive stimulators’ were the most damaging. Aggressive stimulators were defined as being challenging, confrontational, charismatic, authoritarian, caring and self-revealing. A study by Ricks (1974) is also described, which examined two therapists working with adolescent boys, a highly successful therapist termed ‘supershrink’ by the boys and another therapist whose clients had poor outcomes, referred to as ‘pseudoshrink’ (Bergin & Suinn, 1975). Ricks found that the successful therapist devoted more time to boys who were most disturbed, whereas the unsuccessful therapist did the opposite, seeming to avoid or fear them. The unsuccessful therapist also seemed to become caught up in the negative feelings or hopelessness of clients, inadvertently reinforcing these states.

Finally, the 'complex interaction' between client and therapist is acknowledged; what one client finds helpful, another may find harmful (Lazarus, 1971). They discuss previous research around therapists offering high versus low conditions of empathy and positive regard (Truax, 1963). They propose that difficult or aggressive clients may negatively affect therapists who show low levels of empathy and positive regard, whereas therapists showing high levels are less affected, resulting in higher success rates for the latter. Race and class is also discussed in terms of whether it is more helpful for therapist and client to be of the same ethnicity or socioeconomic status. They present mixed results, so it is unclear whether it makes a difference having a different or similar therapist to oneself. This chapter provides a useful framework from which to begin thinking about factors associated with negative change.

Mohr (1995) Negative outcome in psychotherapy: A critical review

Mohr conducted a critical review of 42 studies which mention negative outcome during therapy. Nineteen of these studies were discussed in the previous chapter by Lambert et al., (1977). Outcome studies ranging from controlled trials to case studies were included, and these varied in terms of the depth of discussion around negative change. Some studies included merely mentioned a prevalence rate for negative change in relation to an intervention (Garfield & Bergin, 1971). Although it claims to be a critical review, there is little discussion of methodological issues. Issues identified include a lack of control group; present for 31 of the studies, 4 studies which used students instead of patients, two studies where patients were hospitalised, a potential confounding variable for therapeutic outcomes, and studies where patients were given Electro-convulsive Therapy (ECT) and it was not clear if controls or patients received ECT. It was sometimes unclear what type of therapy people had received and the way in which negative change was measured varied. Some studies

combined negative change with no change, cited as an issue, since previous research had suggested that the two groups may be qualitatively different (Mohr et al., 1990).

Mohr identifies patient, therapist and therapy variables which appeared to be associated with negative change in the studies reviewed. In terms of the client, a Borderline Personality Organisation, Obsessive-Compulsive traits, interpersonal difficulties, initial high symptom severity and poor motivation were cited, echoing most findings from Lambert et al (1977). One study also highlights 'those who expect therapy to be painless' (Foa & Steketee, 1977) as being at risk of negative treatment outcomes. Therapist-related factors found to be associated with negative change were; low levels of empathy, underestimating the severity of a client's difficulties, negative countertransference, poor technique, making a greater number of transference interpretations and disagreement with the client about the process of therapy. Different therapeutic modalities are also discussed in the review and it is acknowledged that all modalities can produce negative change, but experiential groups or Gestalt therapies are highlighted as more often associated. Due to methodological issues it's difficult to draw firm conclusions from Mohr's review. In terms of implications for further research, he discusses how deterioration is defined and advocates using Jacobson and Revenstorf's (1988) clinical significance criteria to identify when negative change has occurred. He also discusses the use of specific vs global outcome measures to monitor the occurrence of negative change, stating that global measures are preferable as they pick up on phenomena like symptom substitution and deterioration in domains other than the target symptom.

Lilienfeld (2007) Psychological Treatments that cause Harm

This review has been used alongside Mohr's as a basis for interventions attempting to target and prevent negative change (Probst, Lambert, Loew et al., 2013). Lilienfeld conducted a systematic review of studies from the Psycinfo database, looking for specific therapies which

have caused harm to patients. He discusses various ways in which therapy may cause harm and reviews psychological therapies that have been known to do so. He concludes that treatments which probably cause harm for some clients are; Critical Incident Stress Debriefing, typically a group intervention aimed at preventing the occurrence of PTSD, 'Scared Straight' programmes for children at risk of criminality, Facilitated communication for children diagnosed with Autism, Attachment therapies such as rebirthing, Recovered memory techniques, Dissociative Identity Disorder (DID) Oriented Psychotherapy, grief counselling for normal bereavement, Expressive-Experiential psychotherapies, boot camp interventions for Conduct Disorder and Drug Abuse and Resistance Education (DARE) Programs. Other treatments described as possibly causing harm for some clients are; Peer-Group Interventions for Conduct Disorder and Relaxation Treatments for Panic-Prone Patients.

Lilienfeld discusses limitations of the evidence base around deterioration effects, arguing that some estimates may be too large, as they include negative effects unrelated to the treatment given, or too small because some improvements may have been greater without treatment. This highlights the need for studies to include control groups not receiving treatment, in order to know whether treatment is the likely source of deterioration. The aforementioned therapies are described as probably causing harm because evidence comes from Randomised Controlled Trials (RCTs), with findings replicated by independent researchers, or research indicating a consistent occurrence of adverse events following the introduction of therapy. Lilienfeld's review contrasts 'potentially harmful treatments' with 'empirically supported therapies' (ESTs) and appears to assume that any negative effects which occur when therapy is evidence-based may be due to external events, therapist or client factors, as opposed to other factors such as the therapeutic process. The review does not consider negative change

occurring in the course of ESTs but acknowledges that the evidence base around ESTs often comes from studies which are not methodologically sound.

Summary and rationale for current review

On the basis of previous reviews the following correlates of negative change have been identified. In terms of client factors, Borderline Personality Organisation, Obsessive-Compulsive traits, bulimia, panic, poor motivation, expecting therapy to be painless, more interpersonal problems, initial high symptom severity, chronic conditions, multiple previous therapies, somatoform disorders, comorbidity, being single and less educated have all been implicated. In terms of therapist factors; low levels of empathy and warmth, underestimating client issues, poor technique, high numbers of transference interpretations and disagreement with the client by the therapist have been implicated. In addition to these, specific therapies have been identified which may cause harm.

The reviews discussed looking specifically at negative change in mainstream or evidence-based therapies, are not up to date, the most recent being 1995, so there is a need to review current research. The studies identifying correlates often had many methodological issues. In addition, studies included in both the Mohr (1995) and Lambert, Bergin and Collins (1977) were conducted at a time when therapy may have looked different and been less regulated than it is today. For example, in the UK, the United Kingdom Council for Psychotherapy only began regulating in 1985 (Antrican, 2009), eight years after Lambert, Bergin and Collins (1977) review. Also, psychotherapy is now more frequently carried out by psychologists or trained therapists as opposed to psychiatrists. It's important to consider whether correlates identified are still relevant in explaining negative change and whether we can substantiate the findings of previous research.

Review Aims

This review aims to establish current knowledge about negative change during psychotherapy by conducting a review of the literature. It will consider the evidence base to establish whether knowledge concerning factors linked with negative change has advanced. It will also explore what clinicians might do to intervene to prevent negative change, thinking about implications for practice and future research.

Methodology

Following preliminary searches, the terms used in this review were:

Psychotherapy AND (Deteriorat* OR 'negative change' OR 'Negative treatment outcome')
AND treatment outcomes

The Boolean operator AND was used to combine unrelated terms and OR was used to ensure that a term related to negative change appeared in the results. The truncation symbol (*) was used to ensure no studies or articles were missed due to alterations of terms used. Database mapped terms were used for the terms 'psychotherapy' and 'treatment outcomes'. No date range was specified.

Terms were searched in PSYCINFO, Web of Science, Cochrane Reviews and Ovid Medline databases in December 2015. Abstracts and titles were screened to ensure that results included some discussion around or research regarding negative change. Studies and articles were included if they looked for factors associated with negative change in adult clients, attempted to reduce negative change or discussed interventions targeting this phenomenon. Studies and articles were excluded if;

- They were not English language

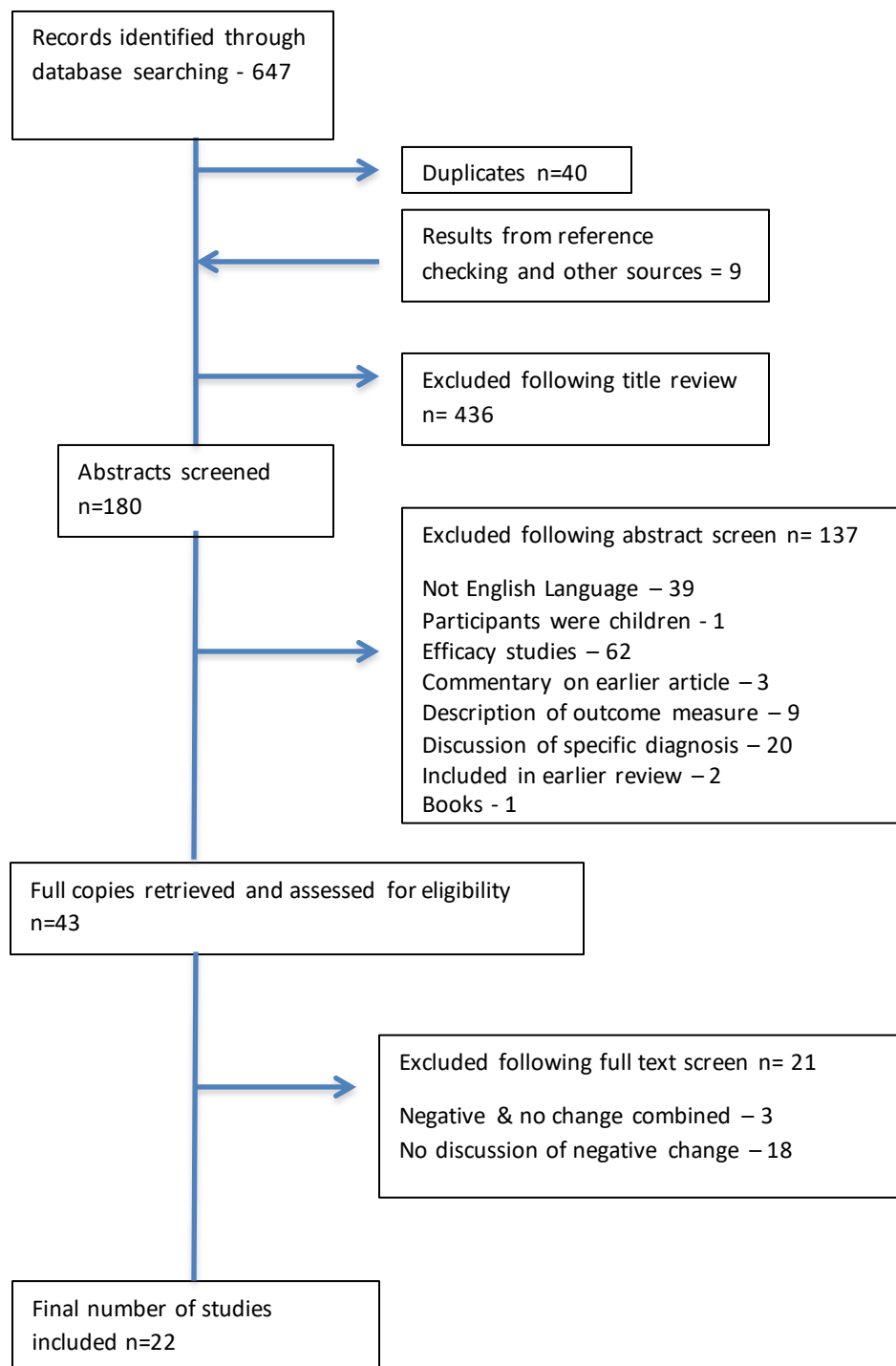
- They mentioned negative change, for example as part of an efficacy study for a specific intervention, without discussing reasons or associations
- Clients who experienced deterioration were combined with those experiencing no change in the analysis (Werbart, Von Below, Brun & Gunnarsdottir, 2014) or a ‘treatment failure’ was presented where it was unclear whether negative or no change had occurred (Gold, 1995)
- Negative change was only experienced by waiting list controls
- They just described outcome measures (Youn, Kraus & Castonguay, 2012).
- They were discussed in an earlier review
- Entire books were excluded as beyond the scope of this review

University dissertations were searched via the Canterbury University Create database using the search terms;

Psychotherapy AND (deteriorat* OR negative change)

No results were found on this database.

Figure 1: Flowchart of literature review search process



Critique

To assist with study evaluation, a checklist was devised combining items from quality assessment tools by the 'Effective Public Health Practise Project' (EPHPP, 2009) and the Critical Appraisal Skills Programme (CASP, 2013) (see Appendix A). This checklist was referred to when evaluating the contribution of research studies to the conclusions of this review.

Literature review

Twenty-two articles including research studies, articles in peer-reviewed journals and book chapters are included. For the purposes of this review, articles have been grouped together according to subject matter. Articles which aim to define or describe negative change will be discussed, followed by those which attempt to explain or identify correlates. Finally, research around detecting and preventing negative change will be reviewed. Table 1 lists included articles, divided into the sections in which they appear in the review, and in chronological order within these sections.

Table 1: Studies and articles reviewed

Studies defining, describing and measuring negative change

Authors	Study	Design	Participants	Findings
1.) Bystedt, Rozental, Andersson, Boettcher & Carlbring (2014)	Survey asking therapists about negative change, its occurrence and their understanding of this.	Qualitative survey study, analysed using thematic analysis	74 therapists from Sweden	Therapists agreed that negative change could be an issue in therapy but were less clear on how to operationalise this and most not familiar with current evidence base
2.) Kachele & Schachter (2014)	Article discussing side effects, destructive processes and negative outcomes in psychoanalytic therapy	Article		Describes negative change as something therapists avoid addressing. Factors implicated; incorrect diagnoses, external conditions, constitutional factors, unfavourable modifications of ego and transference or countertransference.
3.) Linden (2013)	Article describing and defining negative effects	Article		Definitions of 'unwanted events'; Treatment-emergent reactions, Adverse treatment reactions, Malpractice reactions, Treatment non-response, Deterioration of illness, Therapeutic risk and Contraindications
4.) Barlow (2010)	Article reviewing negative effects and methodologies	Article		There has been progress in refining methodologies for psychotherapy research, resulting in clear evidence for positive effects of psychotherapy. However, negative change has not been given comparable attention. More research needed, including the use of individual, idiographic approaches.
5.) Swift, Callahan, Heath, Herbert & Levine (2010)	Study investigating the course of deterioration in therapy. In particular addressing the questions of whether negative change occur in line with the psychotherapy phase model (Howard, Leuger, Maling & Martinovich, 1993), by looking at the course or pattern occurring when individuals experienced deterioration	Naturalistic observation of clients in therapy and students not in therapy.	Study 1 – 135 clients Study 2 – 914 students	For 158 individuals who deteriorated, demediation reliably preceded debilitation which preceded demoralisation

6.) Mohr (1995)	<i>Talks about 'proscription' - actions which should be prohibited rather than prescribed. He describes 5 interactions between therapist and client which may indicate increased risk of negative change</i>	Article	-	Interactions which indicate potential deterioration; Anticipation of emotional pain and therapeutically induced arousal, client suspiciousness and therapist empathy, level of interpersonal functioning, diagnosis and treatment modality, relaxation and the <i>patient's need for control</i> .
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Studies and articles examining factors which contribute to negative change

7.) Probst, Lambert, Loew, Dahlbender, Reiner & Tritt (2015)	Used OQ analyst to calculate expected recovery curves and identify extreme positive (EPD) or extreme negative (END) deviations from this (1 SD was used) and looked for associations with therapeutic alliance, social support, motivation, life events	Expected recovery curve deviations with 4 ASC (Assessment for signal cases) scales added as covariates	271 Psychosomatic inpatients	Each ASC scale was positively associated with EPD but only the social support and life events scales were negatively related to END, suggesting that interventions might focus on social support and life events
8.) White, Lambert, Ogles, McLaughlin, Bailey & Tingey (2015)	Using the Assessment for Signal Clients as a feedback tool for reducing treatment failure. Response and scores analysed	Cluster analysis & log-linear modelling	107 'off-track' clients from hospital based outpatient clinic	3 off-track client types – problems with alliance, social support and life events or those with 'indistinguishable patterns'
9.) Shepherd, Evans, Cobb & Ghossain (2012)	Clients identified from IAPT service as having deteriorated. Therapists given survey to fill out regarding their opinion on why deterioration had occurred. Data analysed using thematic analysis	Survey study analysed using Thematic Analysis	27 therapists who had seen 43 clients with deteriorating scores on the CORE measure	Therapists' explanations of negative change mostly focussed on the client not the therapist. Most frequently mentioned was that the intervention was not suitable or that the clients had become more aware of their difficulties

Therapeutic process

10.) Falkenstrom, Grant, Broberg & Sandell (2007)	Client who received psychoanalytic therapy interviewed 1 and 2 years after termination to explore their post-treatment processes	Qualitative analysis of interview data and 6 case studies described in detail	20 people interviewed, 3 cases who improved and 3 who deteriorated discussed in detail	Patients who deteriorated showed no evidence of self-analysis. All 3 talked about a sense that therapy was abruptly terminated, by therapist or due to financial issues
11.) Fago (1980)	Looked at outcomes of brief vs longer term therapy with 'rural clients'. Clients seen by two therapists at a community mental health centre. Seven were seen for brief, time-unlimited therapy and 6 were seen longer term. They completed Psychosocial functioning Scale (PSF) before therapy and after each session.	Naturalistic study	13 clients	negative change was more frequent in long-term psychotherapy

Therapist factors

12.) Branson, Shafraan & Miles (2015)	Looked for associations between CBT competence in trainee therapists and client outcome. Trainee therapists competence ratings assigned and analysed, correlations with client outcomes measured	Naturalistic study of trainees enrolled on a CBT training course	43 therapists treating 1247 patients within an IAPT training course	A greater number of clients treated by the least competent therapists experienced reliable deterioration in their symptoms
13.) Okiishi, Lambert, Nielsen & Ogles (2003)	An analysis of therapist effects looking at individual therapist recovery curves and associations between client outcome and therapist factors	Naturalistic study of therapist and client data, using hierarchical linear modelling to generate recovery curves	56 therapist with 1779 clients	When looked at individually, therapists with lowest rates of client improvement usually saw an increase in client symptoms. The only factor found to be associated with this was greater number of treatment sessions

Client factors

14.) Jensen, Mortensen & Lotz (2014)	One year follow up of outcomes following psychodynamic therapy in Denmark. Outcome trajectories, scores from pre, post and at 1 year follow up	Naturalistic psychotherapy evaluation	320 clients from a public psychiatric outpatient psychodynamic group therapy unit. Most had anxiety, personality or mood disorders	6 trajectories classified into three different patterns: early improvers, late improvers and patients with a deteriorating pattern. Correlates identified for each pattern showed that deteriorators had longer duration of illness and less favourable social characteristics
15.) Moos, Moos & Finney (2001)	Investigating baseline predictors of deterioration in patients with substance use disorder. Those who improved, did not respond or deteriorated in response to treatment were included	Case control study	3 groups of 872 patients matched according to number of problems at baseline	Deterioration was predicted by; younger age, African-American race, increased symptoms, number of arrests, prior treatment, recent inpatient admissions, having no close friends. Those with alcohol and drug problems, personality disorder or who were given shorter episodes of care and less visits were also more likely to deteriorate

Detecting and preventing negative change

16.) Hatfield, McCullough, Frantz & Krieger (2010)	An investigation of therapists' ability to detect negative client change, client's case notes were reviewed and compared to outcome measure scores at the same time point. Second study sent a survey to therapists, asking about negative change and what actions they would take.	2 studies Correlation/ Survey	Study 1 – 214 clients case notes reviewed Study 2 – 36 therapists survey responses	21% of therapists referred to negative change, even when there were significant symptoms of deterioration during consecutive sessions, there was no mention of this in the notes around 70% of the time
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The impact of feedback

17.) De Jong, Timman, Van Roijen, Vermeulen, Kooiman,	The impact of patient progress feedback. Benefits of feedback to therapist and client in short-	RCT – conditions – no feedback,	604 patients from psychotherapy	Feedback benefits were strongest for short-term therapy cases that were not
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Passchier & Van Busschbach (2014)	term vs long term therapy were analysed	feedback to therapist, feedback to therapist and client	clinics and outpatient mental health institutes	progressing well when both patient and therapist received feedback. There was a small effect of feedback to therapists and patients in long-term therapies.
18.) Probst, Lambert, Loew, Dahlbender, Gollner & Tritt (2013)	Patient progress tracked using the OQ-45 and the ASC measure. The impact of feedback to therapists was measured in terms of patient outcome.	RCT – patients allocated to feedback or no feedback to therapist conditions	252 patients from psychosomatic clinics	When patients were at risk of treatment failure, feedback to therapists reduced the overall rate of deterioration
19.) Shimokawa, Lambert & Smart (2010)	Review of data from 6 studies investigating feedback interventions; 5 conducted in a university counselling centre and 1 conducted in a hospital outpatient setting.	Meta-analytic & Mega-analytic review	A total of 6151 clients and 291 therapist from 6 studies	CSTs and feedback to therapists appeared effective in preventing treatment failure, but providing feedback to clients showed no effect.
20.) Slade, Lambert, Harmon, Smart & Bailey (2008)	Effects of 4 interventions, aimed at reducing deterioration and enhancing positive outcomes were examined	Randomised Quasi-experimental	3,919 clients from university counselling centre	‘Progress feedback to therapists improved outcomes, especially for cases at risk for a negative outcome, but direct progress feedback to clients did not. Effects were significantly enhanced by using the manual-based CST’
21.) Hannan, Lambert, Harmon, Nielsen, Smart, Shimokawa, Sutton (2005)	A summary of attempts to develop a lab test and statistically derived cut scores for the purpose of identifying potential treatment failures and thereby supplementing therapist judgment and decision making	A linear model for expected treatment response was generated and used to predict outcomes	Data from 492 clients receiving psychotherapy from college counselling centre	Results indicated that formal methods of monitoring were able to identify 100% of the patients whose condition had deteriorated at termination, and 85% by the time they had attended three treatment sessions
22.) Lambert, Whipple, Hawkins, Vermeersch, Nielsen & Smart (2003)	A review of three studies which used feedback from outcome measures with the aim of reducing deterioration during therapy	Meta-analytic review of 3 large scale studies	2605 clients from studies conducted within university counselling centres	The analysis found that using feedback could reduce deterioration by 4% to 8% of cases.

Studies defining, describing and measuring negative change

Bystedt et al., (2014) conducted a survey in Sweden, asking 74 therapists about negative change, its occurrence and their understanding of this. They analysed responses using descriptive statistics and thematic analysis. Core themes emerging from therapists responses were 'characteristics of negative effects, causal factors and methods and criteria for evaluating negative effects'. The types of negative effects described included lack of treatment impact, deterioration, dependency and impact on the client's life. Therapists mentioned potential causal factors as being therapist incompetence or unethical behaviour, harmful treatments, problems with the therapeutic alliance, client factors and external events. The researchers concluded that most therapists agreed that negative change could be an issue in therapy but were less clear on how to operationalise this and most were not familiar with the current evidence base. A methodological limitation of this study relates to using a written survey, which may have restricted responses. Alternatively, interviews may have gathered richer data. The response rate was 5% which is very low and means that results might not be representative of this community, or the wider community of therapists. No inter-rater reliability estimates were calculated for the thematic analysis, impacting on the reliability and validity of the findings, meaning analysis would not be rigorous according to the checklist (Appendix A).

Linden (2013) describes the research base into negative effects as insufficient, not merely due to methodological issues but also because of a lack of agreement about defining, classifying and assessing these. He acknowledges that they are difficult to recognise and study, suggesting that therapists avoid noticing them, or prefer to attribute them to the client. He raises the issue of malpractice if the therapist were to be implicated, stating that it's almost inevitable that therapists will cover up negative change. He defines different types of 'unwanted events' which may occur during, alongside or following therapy; see Table 2.

Table 2: Definition of side effects different from treatment failure, deterioration and malpractice

Side Effects	Definition
Unwanted event (UE)	All negative events that occur parallel or in the wake of treatment
Treatment-emergent reactions (TER)	Any UE that is caused by the treatment
Adverse treatment reactions (ATR)	Any UE that is probably caused by correct treatment
Malpractice reaction (MPR)	Any UE that is probably caused by incorrect or improperly applied treatment
Treatment non-response (TNR)	Lack of improvement in spite of treatment. It is a UE; it can be or cannot be an ATR or an MPR
Deterioration of illness (DOI)	Worsening of illness during therapy or any other time in the course of illness. It is not necessarily a UE; it can be a UE and can be or cannot be an ATR or an MPR
Therapeutic risk (TR)	All ATRs that are known. Patients have the right to be informed about severe or frequent or impairing TR as this is the basis for giving their informed consent for treatment
Contraindications	Conditions of the individual case, which make severe ATR highly probably. An ATR of treatment in spite of given contraindications are one form of MPR

Reproduced from Linden, 2013

Linden proposes that since it is difficult to know whether a UE is treatment related, therapists should assume that they are, unless it is proved otherwise. The case vignettes described demonstrate how difficult it can be to establish what has happened and why, so close observation by the therapist is required throughout the course of therapy.

Kachele and Schachter (2014) cite Linden's work as an important model for defining negative outcomes. They also highlight therapist's avoidance in tackling such issues. However, much of the outcome research they discuss relates to early research cited in previous reviews (Ricks, 1974; Strupp, Hadley & Gomes-Schwartz, 1977) particularly in relation to therapist factors. In relation to psychoanalytic therapy, they cite issues with countertransference as hugely important but often ignored.

Barlow's (2010) article discusses 40 years of research into negative change, highlighting methodologies used and also referring to avoidance around reporting. He notes that psychologists were originally trained to expect negative change but it is no longer given such emphasis on training courses. Barlow advocates research which takes into account individual differences, using individual case studies, latent growth curves and multilevel modelling to establish the prevalence, patterns and predictors of change. He also talks about clinical practise guidelines developed by the American Psychological Association (APA, 2002) stating that good outcome research should discuss negative effects or side-effects, but giving no further guidance as to how these should be defined. He highlights the work of Michael Lambert as pioneering in terms of tracking and examining deterioration effects, proposing that future research must examine such effects systematically, using refined methods such as the single-case procedures discussed.

Swift et al., (2010) looked at the course of negative change and whether it occurs similarly to positive change, following a specific psychotherapy phase model (Howard et al., 1993).

They observed change in clients receiving therapy from a training clinic, finding that increased symptoms reliably preceded a decreased sense of well-being and decreased functioning. It's unclear how useful this finding may be in terms of understanding or intervening to prevent negative change, impacting on the applicability of the research according to the checklist (Appendix A).

Mohr's (1995) article describes proscription; stating that it's more useful to outline what should not be done in therapy, than to prescribe interventions. For the most part, he uses research from his 1995 review to decide on rules for 'proscription' and so talks about clients who expect therapy to be painless, those who are suspicious towards the therapist, who have severe difficulties with interpersonal relationships and borderline personality organisation as those to be aware of. He also warns about using relaxation based treatments with clients who

have a high need for control. He states that looking out for these factors can help therapists to make decisions which 'do no harm'.

In terms of knowledge around negative change then, it seems therapists might be aware of its occurrence and some associated factors, but might be less clear on how to operationalise it. There are many potential types of deterioration so it might not be easy to pick out worsening that is due to therapy rather than other factors. To find out more information about negative change and its course, using single case methodologies may be more useful than group means.

Studies and articles examining factors which contribute to negative change

As part of a service case review Shepherd et al., (2012) conducted a survey of therapists who had provided therapeutic input for 43 clients identified as having 'deteriorated' according to the Clinical Outcomes in Routine Evaluation (CORE-OM, Evans et al, 2002) measure.

Therapists were asked why they thought negative change had occurred. The reasons given mostly related to client factors, with the most frequent being that the intervention was not suitable, that clients had become more aware of their difficulties, there had been difficulty with ending or there were ongoing negative life events. In fact, as the authors discuss, some clients were at risk of showing score deterioration due to having lower scores to start with, meaning that there was not as much scope for positive change, but only nine of the therapists mentioned this. Therapists never attributed negative change to their own actions or skill.

Although this was a small study, the rate of negative change was comparable to that found in other, larger audits. The results may provide a useful insight into how therapists interpret or understand negative change although the real reasons behind negative change could not be verified.

A recent study (Probst et al., 2015) looked at expected recovery curves according to the Outcome Questionnaire Analyst (Lambert, 2012) and identified German in-patients who showed extreme positive (EPD) or extreme negative deviations (END). They then looked for correlates from the Assessment for Signal Cases (ASC) measure which records therapeutic alliance, social support, client motivation and life events. This study was methodologically good, with a large sample of patients being randomised to therapy or control groups, using reliable and valid outcome measures. However, the therapy drop-out rate was not reported and the in-patient context described may differ from contexts where therapy is usually offered. The results found that items from the ASC were positively related to EPDs but only social support and life events were negatively related to ENDs, whereby less social support and negative life events were associated with negative change. These results suggest that clients in the study did not do badly as a consequence of therapy and that interventions should target the social support and structure around clients if possible.

White et al. (2015) also used the ASC measure to look for correlates when therapy was 'off-track' or not successful, finding again that the greatest issue might be social support.

However, motivation and the therapeutic alliance were also implicated.

Two of the previous studies imply that life events play a key role in negative change, although according to Linden, they would not be defined as Treatment-emergent reactions.

Interestingly, Shepherd's comments about low scores at baseline also seem to contradict other findings about initial symptom severity being associated with deterioration, as identified in Mohr's (1995) review.

Therapeutic process

The outcome study by Fago (1980) is discussed since it was absent from previous reviews.

The study included 13 clients who filled out the Psychosocial Functioning Scale (PSF: Fago,

unpublished) before starting therapy and after each subsequent session. The PSF consists of 16 statements relating to psychological and social functioning and can be filled out by the client or an observer. Two therapists filled out the observer measure after each session. Clients were not randomly allocated to condition and there is no mention of why some received longer-term versus brief therapy. The results found that negative change was more frequent in long-term psychotherapy. However, the groups were found to differ at baseline, with clients who received long-term interventions having a higher PSF score, meaning their problems were more severe, although the authors state that this difference was statistically corrected through the use of Analysis of Covariance (ANCOVA). The findings also state that longer-term therapy clients showed most improvement during the first four sessions, after which only one client continued to show improvement, three showed no further change and two showed evidence of deterioration.

Although acknowledging methodological flaws, the authors claim that a favourable effect of brief therapy is demonstrated, stating that often clients show initial improvement, followed by a plateau effect or deterioration in their symptoms. They cite work by Watzlawick, Weakland and Fisch (1974), suggesting that long-term therapy aims to achieve unattainable or utopian goals, valued by the therapist more than the client and therefore leading to client resistance. A separate finding from this study was that therapists tended to rate clients receiving long-term therapy as more improved, whereas clients' scores showed the opposite pattern, supporting the claim that therapists' and clients' views about necessary change may differ. According to the checklist the study is not methodologically sound: it's a very small sample, with no control group, clients were not randomly allocated and the measure used was unpublished so we cannot know if it was reliable or valid. However, ethically it might be difficult to randomly allocate clients if clinicians believed longer term work was indicated. The therapy was described as 'active eclectic', incorporating both behavioural and non-

behavioural techniques; it's difficult to know if the findings would generalise across therapeutic modalities.

Falkenstrom et al., (2007) describe three case studies of clients who appeared to experience negative change following psychoanalytic therapy, concluding that one thing they had in common was a sense that therapy was unfinished or 'abruptly terminated'. Again this is evidence from a small sample although case studies provide rich data which might be helpful in considering negative change holistically, looking at the whole person, their situation and factors which may impact on therapy. It might be useful to get feedback from a larger sample of clients in terms of their feelings about therapy in the context of negative or positive change.

Methodological issues with studies looking at process mean it's difficult to generalise findings, but they suggest that longer-term therapies or abrupt termination, perhaps occurring before the client is ready, may be problematic for some. There are also suggestions that therapists and clients may have a different view about what change has occurred.

Therapist factors

Previous reviews emphasised the role of therapist characteristics in negative change, but this review found few studies looking into this. Recent research seemed more focussed on easily measured factors, such as level of training or therapist demographics.

Branson, Shafran and Miles (2015) conducted a naturalistic study of trainee therapists delivering a CBT intervention within an IAPT (Improving Access to Psychological Therapies) training service in the UK. Looking at the sample overall, they found no correlation between therapist competence and client outcome. However, when therapists were divided into three groups according to competence, clients treated by the least competent therapists showed a higher than expected rate of deterioration in their symptoms.

Competence was assessed using the Cognitive Therapy Scale Revised (CTS-R; Blackburn et al., 2001) which includes some factors that might be shared across therapeutic modality, for example; interpersonal effectiveness and the facilitation of emotional expression, but other factors are more specific to cognitive therapy such as agenda setting or identification of key cognitions, so competence encompasses adherence to the model. In terms of the checklist, this study was not randomised or controlled and there was no attempt to control for confounds between groups. Measures used were shown to be valid and reliable and a low drop-out rate was reported. However, the effect found was modest and the study offers no further information about whether certain aspects of competency according to the CTS-R were specifically related to negative change, which would have been useful to know.

A study carried out by Okiishi, Lambert, Nielsen and Ogles (2003) used hierarchical linear modelling to look at individual therapist recovery curves, finding evidence that certain therapists could be termed ‘supershrinks’ due to exceptional rates of change. One therapist also stood out as a ‘pseudoshrink’ due to an average client worsening of 5.75 according to the OQ. The study looked for associations between client outcome and therapist factors, finding no differences in client outcome based on therapist gender, level of training, type of training or theoretical orientation. It was therefore not able to offer suggestions about what was different about the therapist who saw worsening clients, although there was some evidence that lower performing therapists saw clients for a longer time on average.

Swift et al., (2010) assumed that training centres were likely to see evidence of deterioration, concluding that it was more likely to occur with trainee therapists because of a higher rate of ‘premature termination’, or therapeutic input ending before it was complete (Callahan, Aubuchon-Endsley, Borja & Swift, 2009). However, the studies reviewed here do not provide evidence to support this. Branson et al., (2015) concluded that the majority of therapists may be good enough, with a small number of highly effective therapists achieving

superior outcomes. It seems we are no closer to identifying characteristics of superior or inferior therapists than at the time of Lambert and Bergin's chapter (1977).

Client factors

Some studies have looked for predictors of negative change in clients. Moos, Moos and Finney (2001) looked at a large sample of clients with substance misuse issues who had received psychotherapy in the USA, comparing baseline factors for those who improved, experienced no change or deteriorated. Clients were matched in terms of their presenting problems and the study found that those who deteriorated were more likely to be younger, African-American and to earn less. They were more likely to have received inpatient care, be known to the criminal justice system and to have both alcohol and drug problems. They had less social support, more interpersonal problems and three or more severe psychiatric symptoms. The prevalence of deterioration cited in this study was 10%. The authors note limitations due to a predominantly male sample and a lack of information about the input people received. They state that therapy used for substance misuse issues may also be more confrontational than other psychotherapy; proposed as an explanation for the increased rates of negative change in this population.

Jensen, Mortensen and Lotz (2014) conducted a naturalistic study of a large sample of clients who received psychodynamic therapy in Denmark. They constructed change trajectories of clients using pre, post and one year follow up scores from the Symptom Check List-90 (SCL-90; Derogatis, 1983), dividing participants into three groups; early improvers, late improvers and those experiencing deterioration. Having divided clients into groups they looked for social and demographic correlates, finding that those who experienced deterioration were significantly different from early improvers. They had been unwell for a longer duration and

had less favourable social characteristics, in terms of social support available, the extent of social burdens and a greater occurrence of both economic and family problems.

These findings support evidence from earlier reviews, suggesting that severity of symptoms, a lack of social support, interpersonal difficulties and low socio-economic status are characteristics which might be linked with worsening during therapy. However, it could be useful to look at commonly used UK-based interventions, such as counselling or Cognitive-Behavioural Therapy, to see if similar correlates are present.

Detecting and preventing negative change

Research in this area has been dominated by Michael Lambert and his colleagues, who have written extensively about the prevalence of negative change, how best to detect and measure it and thus intervene early to prevent it (Lambert & Bergin, 1994; Lambert, Whipple, Bishop et al., 2002; Lambert, Whipple, Smart et al., 2001). A call for clinicians to obtain feedback by routinely monitoring patient outcome (Lambert et al., 2003) came out of research which suggested that therapists are not good at detecting negative change in their clients, perhaps due to a self-assessment bias or an overly positive view of their own work (Walfish, McAlister, O'Donnell & Lambert, 2012). Hatfield et al. (2010) conducted two studies investigating therapists' ability to notice negative change and make treatment decisions on the basis of this. When clients showed evidence of reliable deterioration according to the Outcome Questionnaire (OQ-45), the authors examined clinical case notes from the same time point, to look for mentions of worsening. They found that only 21% of therapists referred to negative change and even when there were significant symptoms of deterioration during consecutive sessions, there was no mention of this in the notes around 70% of the time. In terms of actual responses, 23.8% of therapists continued treatment as usual, 19% changed the treatment implementation and 23.8% made a referral for medication. In 33.3%

of cases it was unclear if the therapist made any changes, as their notes merely referred to the session content. This contrasts with results from their second study; a survey of therapists asking about client deterioration and what action they would take. Half of therapists mentioned a medication referral and approximately a third said they would discuss deterioration with the client, increase the number of sessions, modify treatment or consult with peers. We cannot know that therapists did not consult with their peers and it's difficult to know what level of detail would be expected in the clinical notes; this can vary across clinicians and services, which is a potential limitation. However, a mention of deterioration would be expected and in two cases therapists noted that clients appeared to have improved, which is concerning.

The impact of feedback

Using large datasets, Brown and Lambert (1998) found that it was possible to predict outcome by combining initial severity of symptoms with change after one session, leading to their development of a 'rationally derived method' to identify cases at risk of treatment failure (Lambert, Whipple, Bishop et al., 2002). In 2004, Lambert briefly outlines negative change, highlighting the fact that therapists are poor at noticing and predicting deterioration and promoting the use of feedback in clinical practise. He subsequently develops the Outcome Questionnaire-45 (OQ-45); a self-report measure intended to gather information about subjective discomfort, interpersonal relationships and social role performance, suitable for repeated administration during therapy (Lambert et al., 2004).

Lambert, Whipple, Hawkins et al. (2003) conducted a meta-analysis of three studies (Lambert, Whipple, Smart et al., 2001; Lambert, Whipple, Vermeersch et al., 2002; Whipple, Lambert, Vermeersch et al., 2003) which used feedback from outcome measures with the aim of reducing deterioration during therapy. All the studies took place in college counselling

centres. Participants were randomly assigned to feedback or no feedback conditions, were matched in terms of age, gender and race and therapists saw both experimental and control participants, using a variety of treatment approaches. These studies would be rated highly according to the checklist. The second study was a replication of the first Lambert et al. (2001) study but the third study also encouraged the use of Clinical Support Tools (CSTs). CSTs (Lambert, Bailey, White, Tingey & Stevens, 2015) are described as problem solving strategies, to be used when clients show evidence of deterioration. When deterioration is predicted, an ASC measure is given to the client. This measure looks for potential issues in four areas: The therapeutic alliance, social support, motivation, and stressful life events. The manual also provides advice for action in each of the four areas. For example, if the therapeutic alliance is indicated, the therapist may want to work on ensuring they have the same goals or ask for feedback, whereas if motivation is implicated, questions based on Miller and Rollnick's (2002) motivational interviewing techniques are advised. In total, 2,610 clients were included in the study analyses. The outcome of this analysis found that using feedback could reduce deterioration by 4 - 8% of cases.

A later review by Shimokawa, Lambert and Smart (2010) includes three studies from the previous review plus three additional papers (Harmon et al., 2007; Hawkins, Lambert, Vermeersch, Slade, & Tuttle, 2004; Slade, Lambert, Harmon, Smart, & Bailey, 2008), conducting meta-analytic and mega-analytic reviews to summarise the effectiveness of feedback and CSTs in improving outcome for clients both at risk or not at risk of treatment failure. One study (Hawkins et al., 2004) was conducted in a hospital outpatient setting. Both CSTs and providing feedback to therapists appeared to be effective in preventing treatment failure, but providing feedback to clients showed no effect. They discussed giving feedback to clients, proposing that it may enhance outcomes for some whilst having the opposite effect for others, depending on the individual. Giving feedback to clients that they

are not improving is something that would need careful and sensitive delivery. For example, clients who are depressed may too easily see it as evidence that they have failed.

In contrast, De Jong, Timman, Hakkaart-Van Roijen et al. (2014) conducted a randomised-controlled trial which found that feedback to clients could be helpful in reducing deterioration. They compared the use of feedback in long and short-term therapy and found greater benefits when both patient and therapist received feedback on progress for clients not progressing well in short-term therapies. There was also a small effect of feedback to therapists and patients in long-term therapies. They concluded that feedback to clients could be effective due to associated feelings of empowerment.

A later study (Probst, Lambert, Loew et al., 2013) looked at the impact of feedback in an in-patient setting. Patients from two psychosomatic clinics were randomised to feedback versus non-feedback conditions and all were tracked using the OQ-45 measure. The findings supported earlier results, demonstrating that when patients were at risk of treatment failure, feedback to therapists reduced the overall rate of deterioration.

Studies by Lambert, Whipple, Bishop et al. (2002) and Hannan et al. (2005) examined the accuracy of using algorithms based on data from the OQ-45 to predict deterioration in therapy, finding that these were able to identify 85% of patients who would deteriorate after three sessions. In future studies, Lambert incorporates the OQ-analyst; a computer programme using data from the OQ to track client progress and provide feedback to therapists (Lambert, 2012).

It's notable that while Lambert's research on feedback pays attention to methodological issues such as randomisation and control groups, with most studies scoring highly according to the checklist referred to in this review, it seems that CSTs might be based on early research with significant methodological limitations. In addition, for the most part, Lambert's

conclusions about the usefulness of outcome measure feedback is based on research using university counselling centre clients as participants. In this setting participants would more likely be well-educated, so written outcome measures may have been more useful and presented less problems than when they are used with the general population or those who present at primary care services.

Overall, these studies appear to find unanimous support for providing feedback to therapists. CSTs may also be helpful in deciding on a course of action in the event of client deterioration. However, it would be useful to have the findings validated by independent researchers in a wider variety of settings.

Discussion

This review has attempted to summarise current research into negative change in psychotherapy. Although many clinicians know about the potential for negative change, they may not have a good awareness about the current evidence base or be trained to look out for its occurrence in their day to day work (Barlow, 2010). Evidence also suggests that therapists are not good at picking up on negative change in their clients (Hatfield et al., 2010). However, because of methodological issues it is often difficult to know if negative change is due to therapy or external factors (Linden, 2013). Negative outcomes can be divided into subtypes and it's not always easy to see what has caused side-effects or deterioration. Single case methodologies may be the best way to pick up on therapy induced negative change and look for associated factors, but so far few researchers have utilised these methods. However, outcome measures such as Lambert's OQ do attempt to factor in external life events to the prediction of negative change, which is important to help identify when this is truly therapy-induced.

Therapeutic process

This review found some evidence that longer term therapy might be associated with negative change, although this is based on small samples and studies which would be rated as methodologically weak according to the checklist (see Appendix A). However, studies looking at therapist characteristics also found that therapists with the lowest success rates saw their clients for longer on average (Okiishi et al., 2003). This finding may be of limited importance to current public mental health provision, since due to financial considerations, few clients might be offered long-term therapy. However, it's important that clinicians working privately are aware of this concern and work ethically and responsibly with their clients. Another factor suggested from analysis of individual case studies was abrupt termination and the danger of therapy ending when the client is not ready. It would be interesting to know whether therapists had a similar view of the ending in these cases, or if clients with positive outcomes also had such feelings and yet still improved in their mental well-being.

Client Factors

Evidence was found for the following correlates among clients: having more interpersonal problems, initial high symptom severity, less favourable social characteristics and comorbidity (Jensen, Mortensen & Lotz, 2014; Moos, Moos & Finney, 2001). In addition, this review found evidence that lower levels of social support may be implicated in negative change (Probst et al., 2015). The results tie in with findings from previous reviews (Lambert et al., 1977; Mohr, 1995). No additional support was found for factors such as Borderline Personality Organisations, Obsessive-Compulsive traits, bulimia, panic, poor motivation, expecting therapy to be painless or somatoform disorders.

Therapist Factors

There were no recent studies found looking at levels of empathy and warmth in therapists, so these correlates, as noted in previous reviews, cannot be substantiated. However, two studies did implicate levels of therapist training as being associated with negative change (Callahan et al, 2009; Bransan, Shafran & Miles, 2015) although it may only be the lowest performing therapists who see evidence of increased deterioration rates.

Okiishi et al. (2003) found some evidence that poorly performing therapists saw clients for a greater number of sessions on average. This ties in with Fago's (1980) finding that longer term therapies resulted in higher rates of deterioration. Falkenstrom also cited abrupt termination of therapy as a factor, which Callahan et al. (2009) also propose as a reason why deterioration occurs more frequently in training clinics.

Therapies

This review did not look for further evidence of specific therapies thought to cause harm. However, experiential or gestalt therapies are no longer prevalent and the majority of outcome research appears to focus on mainstream therapies such as CBT.

Interventions

Research attempting to intervene and reduce negative change has focussed on using outcome measures, feedback to therapists and CSTs to alert therapists when negative change may be likely to occur and suggest potentially helpful interventions. This review found evidence that feedback to therapists, and sometimes to clients about progress, may help to prevent treatment failure (Shimokawa et al., 2010) particularly when accompanied by guidance about what course of action might be useful. However, further research in this area with patients outside of university counselling centres would be useful. This would provide evidence that such outcome measures can be used effectively with clients who are more diverse in terms of

education, race, age and social background. It would also ensure that practitioners, as opposed to academics, were able to use the measures effectively.

Implications for research

As Lambert et al. (1977) point out, it's difficult to conduct rigorous studies of therapy, using control groups and random allocation, whilst still acting ethically. However, there are areas which would benefit from more current research. Very few studies looked at client explanations of negative change; the only one this review identified (Werbart et al., 2015) carried out interviews with 'non-improved clients', but combined negative change with no change, potentially confounding the findings in light of findings that the two groups may be qualitatively different (Mohr et al., 1990). In addition, CSTs have been based on past research with methodological flaws and patients were not directly interviewed about changes they thought would have helped.

There is a need for more rigorous research in this area and services which use outcome measures routinely as part of their practice may be well placed to facilitate this. Research on correlates has often used questionable methodologies and sometimes uncovered mixed results. To improve the evidence base there is a need for more studies recording data from control groups not receiving therapy. Researchers must also consider using single case methodologies to detect and analyse negative change and highlight variance in clients' outcomes instead of using group means which may conceal deterioration. Longitudinal studies may also be useful to identify causal relationships.

In terms of findings around abrupt endings and other correlates related to process it would be interesting to know whether clients and therapists had a similar view of the therapy. It would also be useful to know if correlates associated with negative change are not also associated with positive outcomes.

Although many clinicians are aware that negative change can occur, they often receive little training around why it might happen and the best course of action to take if negative change is indicated. Future research should aim to provide better information for clinicians so that therapists are better informed in terms of changing the course of suspected deterioration. The work of Michael Lambert into feedback and CSTs has been helpful along these lines, but it would be useful to have a UK-based equivalent, based on a recent evidence base.

A model of negative change

There is not yet a clear model explaining how negative change begins and progresses, although one study found that increased symptoms may precede a decrease in functioning and well-being (Swift et al., 2010). Neither is there an established theory about why negative change happens. Looking to theories of positive change may help to postulate what such a theory might look like. For example, Prochaska and DiClemente's (1984) stages of change model states that client motivation and readiness to change will influence whether therapy is effective and studies have supported this model in relation to therapeutic outcome (Lewis, Simons & Kim, 2012; Lewis et al, 2009). Perhaps negative change may result from a drop back to low levels of motivation such as the pre-contemplation phase, although it's not clear what might drive these clients to continue to attend therapy rather than drop-out. Another theory of positive change is Ryan and Deci's (2000) Self-determination theory, which states that a client's motivation must be intrinsic not extrinsic, for therapy to be successful. In which case, negative change might arise when therapy goals are felt to be coming from the therapist rather than the client; similar to the point made by Watzlawick, Weakland and Fisch (1974).

Thinking more generally it may be helpful to consider Kolb's learning cycle and in particular, variations in learning styles (Kolb, 1984). For learning to occur, it's important to provide

information in a way which means all learning styles are accommodated, whether emphasis is on active doing, watching, thinking or feeling. The ‘accommodating’ learning style combines feeling and doing, in that people prefer to use a hands-on, intuitive approach. Information presented in a didactic, abstract manner may be less helpful for such individuals and it may be important that they are able to learn from experience. It could be that sitting and talking in a therapy room is unhelpful for some individuals so incorporating more behavioural experiments or experiential treatment may be more helpful. To know more about this, research could look more at client personality types and the effectiveness of therapy across a range of approaches.

Implications for practice

It may be useful for clinicians to be aware of factors implicated in negative change and look out for these. For example, enquiring about life events occurring for clients and their social support network. If clients appear to have little social support, efforts could be made to address these issues as opposed to concentrating on one to one therapy. The CSTs devised by Lambert, Bailey, White et al. (2015) can provide a valuable source of advice and support for clinicians but it’s not clear whether they have been used successfully outside of America. Combining CSTs alongside outcome measure feedback in UK clinical settings might be an important step forward and it could feel less worrying for therapists to know that clients are at risk of deterioration if they have a clear action plan. It would be useful for clinicians to keep in mind the possibility of having different views of therapy to the client. This may be in terms of therapy goals or perceptions of the outcome. Regularly checking in with clients could therefore be helpful.

References

- Barlow, D. H. (2010). Negative effects from psychological treatments: A perspective. *American Psychologist*, 65, 13-20.
- Bergin, A. E. (1963). The empirical emphasis in psychotherapy: A symposium. The effects of psychotherapy: Negative results revisited. *Journal of Counselling Psychology*, 10, 244-250.
- Bergin, A. E., & Suinn, R. M. (1975). Individual psychotherapy and behaviour therapy. *Annual Review of Psychology*, 74, 509-556.
- Beutler, L. E., Frank, M., Schreiber, S. C., Calvert, S. & Gaines, J. (1984). Comparative effects of group psychotherapies in a short-term inpatient setting: An experience with deterioration effects. *Psychiatry*, 47, 66-76.
- Binder, J. L. & Strupp, H. H. (1997) "Negative process": A recurrently discovered and underestimated facet of therapeutic process and outcome in the individual psychotherapy of adults. *Clinical Psychology – Science and Practise*, 4, 121-139.
- Blackburn, I. M., James, I. A., Milne, D. L., Baker, C., Standart, S., Garland, A., & Reichelt, F. K. (2001). The revised cognitive therapy scale (CTS-R): psychometric properties. *Behavioural and cognitive psychotherapy*, 29, 431-446.
- Brown & Lambert, M. J. (1998). Presentation at the 29th Annual Meeting of the Society for Psychotherapy Research, Snowbird, UT, USA. Unpublished Manuscript.
- Branson, A., Shafran, R., & Myles, P. (2015). Investigating the relationship between competence and patient outcome with CBT. *Behaviour Research and Therapy*, 68, 19-26.

- Bystedt, S., Rozental, A., Andersson, G., Boettcher, J. & Carlbring, P. (2014). Clinicians' perspectives on negative effects of psychological treatments. *Cognitive Behaviour Therapy*, 43, 319-331.
- Callahan, J. L., Aubuchon-Endsley, N., Borja, S. E., & Swift, J. K. (2009). Pretreatment expectancies and premature termination in a training clinic environment. *Training & Education in Professional Psychology*, 3, 111–119.
- Critical Appraisal Skills Programme. (2013). CASP Randomised Controlled Trial Checklist. Retrieved February 20, 2015 from <http://www.casp-uk.net/#!/casp-tools-checklists/c18f8>
- Clarke, S., Thomas, P., & James, K. (2013). Cognitive analytic therapy for personality disorder: Randomised controlled trial. *The British Journal of Psychiatry*, 202, 129-134.
- De Jong, K., Timman, R., Hakkaart-Van Roijen, L., Vermeulen, P., Kooiman, K., Passchier, J. & Van Busschbach, J. (2014). The effect of outcome monitoring feedback to clinicians and patients in short and long-term psychotherapy: A randomized controlled trial. *Psychotherapy Research*, 24, 629-639.
- Derogatis, L. R. (1983). SCL-90-R. Administration, scoring & procedures. Manual—II. Towson, MD: Clinical Psychometric Research.
- Effective Public Health Practice Project (EPHPP). (2009). Quality Assessment Tool for Quantitative Studies. Retrieved February 20, 2015 from <http://www.ephpp.ca/tools.html>

- Evans, C., Connell, J., Barkham, M., Margison, F., Mellor-Clark, J., & Audin, K. (2002). Towards a standardised brief outcome measure: Psychometric properties and utility of the CORE-OM. *British Journal of Psychiatry*, 180, 51-60.
- Eysenck, H. J. (1952). The effects of psychotherapy: An evaluation. *Journal of Consulting Psychology*, 16, 319-324.
- Fago, D. P. (1980). Time-unlimited brief and longer-term psychotherapy with rural clients. *Journal of Rural Community Psychology*, 1, 16-23.
- Fairweather, G., Simon, R., Gebhard, M. E., Weingarten, E., Holland, J. L., Sanders, R., Stone, G. B., & Reahl, J. E. (1960). Relative effectiveness of psychotherapeutic programs: A multicriteria comparison of four programs for three different patient groups. *Psychological Monographs: General and Applied*, 74, 492.
- Falkenstrom, F., Grant, J., Broberg, J. & Sandell, R. (2007). Self-analysis and post-termination improvement after psychoanalysis and long-term psychotherapy. *Journal of the American Psychoanalytic Association*, 55, 629-674.
- Foa, E. B., & Steketee, G. (1977). Emergent fears during treatment of three obsessive compulsives: Symptom substitution or deconditioning? *Journal of Behaviour Therapy and Experimental Psychiatry*, 8, 353-358.
- Garfield, S. L., & Bergin, A. E. (1971). Therapeutic conditions and outcome. *Journal of Abnormal Psychology*, 77, 108-114.
- Gold, J. R. (1995). Case-report of a failure in psychotherapy. *Journal of Psychotherapy Integration*, 5, 113-120.
- Gyami, A., Shafraan, R., Layard, R. & Clark, D. (2013). Enhancing recovery rates: Lessons from year one of IAPT. *Behaviour Research and Therapy*, 51, 597-606.

- Hannan, C., Lambert, M. J., Harmon, C., Nielsen, S. L., Smart, D. W., Shimokawa, K., & Sutton, S. W. (2005). A Lab Test and Algorithms for Identifying Clients at Risk for Treatment Failure. *Journal of Clinical Psychology*, 61, 155-163.
- Harmon, S. C., Lambert, M. J., Smart, D. M., Hawkins, E., Nielsen, S. L., Slade, K., & Lutz, W. (2007). Enhancing outcome for potential treatment failures: Therapist client feedback and clinical support tools. *Psychotherapy Research*, 17, 379-392.
- Hatfield, D., McCullough, L., Frantz, S. H. B. & Krieger, K. (2010). Do we Know When our Clients Get Worse? An Investigation of Therapists' Ability to Detect Negative Client Change. *Clinical Psychology and Psychotherapy*, 17, 25-32.
- Hoffmann, L. L. (2005). An exploration of the interactions of improvers and deteriorators in the process of group therapy: A qualitative analysis. *Dissertation Abstracts International: Section B: The Sciences and Engineering*, 66, 3411.
- Horwitz, L. (1974). *Clinical prediction in psychotherapy*. New York: Aronson.
- Howard, K. I., Leuger, R. J., Maling, M. S., & Martinovich, Z. (1993). A phase model of psychotherapy outcome: Causal mediation of change. *Journal of Consulting and Clinical Psychology*, 61, 678 – 685.
- Jacobson, N. S., Follette, W. C. & Revenstorf, D. (1984). Psychotherapy outcome research: methods for reporting variability and evaluating clinical significance. *Behavior Therapy*, 15, 336-352.
- Jacobson, N. S., & Revenstorf, D. (1988). Statistics for assessing the clinical significance of psychotherapy techniques: Issues, problems, and new developments. *Behavioral Assessment*, 10, 133-145.

- Jacobson, N. S., & Truax, P. (1991). Clinical significance: a statistical approach to defining meaningful change in psychotherapy research. *Journal of consulting and clinical psychology*, 59, 12-19.
- Jensen, H. H., Mortensen, E. L., & Lotz, M. (2014). Heterogeneity of treatment changes after psychodynamic therapy within a one year follow-up: A replication study.
- Jonsson, U., Alaie, I., Parling, T. & Arnberg, F. K. (2014). Reporting of harms in randomized controlled trials of psychological interventions for mental and behavioural disorders: A review of current practice. *Contemporary Clinical Trials*, 38, 1-8.
- Kächele, H., & Schachter, J. (2014). On Side Effects, Destructive Processes, and Negative Outcomes in Psychoanalytic Therapies: Why Is It Difficult for Psychoanalysts to Acknowledge and Address Treatment Failures? *Contemporary Psychoanalysis*, 50(1-2), 233-258.
- Kan, L. Y., Henderson, C. E., Von Sternberg, K., & Wang, W. (2014). Does change in alliance impact alcohol treatment outcomes? *Substance Abuse*, 35, 37-44.
- Kernberg, O. F. (1973). Summary and conclusion of ‘psychotherapy and psychoanalysis, final report of the Menninger Foundation’s Psychotherapy Research Project. *International Journal of Psychiatry*, 11, 62-77.
- Kolb, D. A. (1984). *Experiential learning: Experience as the source of learning and development* (Vol. 1). Englewood Cliffs, NJ: Prentice-Hall.
- Lambert, M. J. (2010). *Prevention of treatment failure: The use of measuring, monitoring, and feedback in clinical practice*. Washington, DC, US: American Psychological Association.

- Lambert, M. J. (2012). Helping Clinicians to use and learn from Research-based Systems: The OQ-Analyst. *Psychotherapy*, 49, 109-114.
- Lambert, M. J., Bailey, R. J., White, M., Tingey, K. M., & Stevens, E. (2015). Clinical Support Tools Manual – Brief Version 40. OQMeasures LLC.
- Lambert, M. J., Bergin, A. E., & Collins, J. L. (1977). Therapist induced deterioration in psychotherapy. In A. S. Gurman, & A. M. Razin. (Eds.), *Effective Psychotherapy: A Handbook of Research* (first edition, pp 452-481). Pergamon Press Inc.
- Lambert, M. J., Morton, J. J., Hatfield, D. R., Harmon, C., Hamilton, S., & Shimokawa, K. (2004). Administration and scoring manual for the OQ-45.2 (Outcome Questionnaire) (3rd ed.). Wilmington, DE: American Professional Credentialling Services.
- Lambert, M. J., Whipple, J. L., Bishop, M. J., Vermeersch, D. A., Gray, G. V., & Finch, A. E. (2002). Comparison of empirically derived and rationally derived methods for identifying clients at risk for treatment failure. *Clinical Psychology and Psychotherapy*, 9, 149–164.
- Lambert, M. J., Whipple, J. L., Hawkins, E. J., Vermeersch, D. A., Nielsen, S. L., & Smart, D. W. (2003). Is it time for clinicians to routinely track patient outcome? A meta-analysis. *Clinical Psychology: Science and Practice*, 10, 288-301.
- Lambert, M. J., Whipple, J. L., Smart, D. W., Vermeersch, D. A., Nielsen, S. L., & Hawkins, E. J. (2001). The effects of providing therapists with feedback on client progress during psychotherapy: Are outcomes enhanced? *Psychotherapy Research*, 11, 49–68.
- Lazarus, A. A. (1971). *Behavior therapy and beyond*. New York: McGraw Hill.

- Lewis, C. C., Simons, A. D., & Kim, H. K. (2012). The role of early symptom trajectories and pretreatment variables in predicting treatment response to cognitive behavioral therapy. *Journal of consulting and clinical psychology*, 80, 525.
- Lewis, C. C., Simons, A. D., Silva, S. G., Rohde, P., Small, D. M., Murakami, J. L., High, R. R. & March, J. S. (2009). The role of readiness to change in response to treatment of adolescent depression. *Journal of Consulting and Clinical Psychology*, 77, 422.
- Lieberman, M. A., Yalom, I. D., & Miles, M. B. (1973). *Encounter groups: First facts*. New York: Basic Books.
- Lilienfeld, S. O. (2007). Psychological treatments that cause harm. *Perspectives on Psychological Science*, 2, 53-70.
- Linden, M. (2013). How to define, find and classify side effects in psychotherapy: From unwanted events to adverse treatment reactions. *Clinical Psychology & Psychotherapy*, 20, 286-296.
- Masserman, T.H., & Carmichael, H.T. (1938). Diagnosis and prognosis in psychiatry. *Journal of Mental Science*, 84, 893–946.
- Miller, W. R., & Rollnick, S. (2002). *Motivational Interviewing: Preparing people for change*. New York: Guilford Press.
- Mohr, D. C. (1995). Negative outcome in psychotherapy: A critical review. *Clinical Psychology: Science and Practice*, 2, 1-27.
- Mohr, D. C. (1995). The role of proscription in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, 32, 187-193.

- Mohr, D. C., Beutler, L. E., Engle, D., Shoham-Salomon, V., Bergan, J., Kaszniak, A. W., & Yost, E. (1990). Identification of patients at risk for non-response and negative outcome in psychotherapy. *Journal of Consulting and Clinical Psychology*, 58, 622-628.
- Moos, R. H., Moos, B. S., & Finney, J. W. (2001). Predictors of deterioration among patients with substance-use disorders. *Journal of Clinical Psychology*, 57, 1403-1419.
- Okiishi, J., Lambert, M. J., Nielsen, S. L., & Ogles, B. M. (2003). Waiting for supershrink: An Empirical analysis of therapist effects. *Clinical Psychology and Psychotherapy*, 10, 361-373.
- Probst, T., Lambert, M. J., Loew, T. H., Dahlbender, R. W., Gollner, R. & Tritt, K. (2013). Feedback on patient progress and clinical support tools for therapists: Improved outcome for patients at risk of treatment failure in psychosomatic in-patient therapy under the conditions of routine practice. *Journal of Psychosomatic Research*, 75, 255-261.
- Prochaska, J. O., & DiClemente, C. C. (1984). *The Transtheoretical Approach: Towards a Systematic Eclectic Framework*. Dow Jones Irwin, Homewood, IL, USA.
- Rachman, S. J. (1973). The effects of psychological treatment. In H. Eysenck (Ed.), *Handbook of abnormal psychology*. New York: Basic Books.
- Ricks, D. F. (1974). Supershrink: Methods of a therapist judged successful on the basis of adult outcome of adolescent patients. In D. Ricks, M. Roff, & A. Thomas (Eds.), *Life history research in psychopathology. Volume III*. Minneapolis: University of Minnesota Press.

- Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development and well-being. *American Psychologist*, 55, 68-78.
- Shepherd, M., Evans, C., Cobb, S., & Ghossain, D. (2012). Does Therapy make things worse? Investigating episodes of psychological therapy where clients' scores showed reliable deterioration. *Clinical Psychology Forum*, 233, 8-12.
- Slade, K., Lambert, M. J., Harmon, S. C., Smart, D. W. and Bailey, R. (2008). Improving psychotherapy outcome: The use of immediate electronic feedback and revised clinical support tools. *Clinical Psychology & Psychotherapy*, 15, 287–303.
- Sloane, R. B., Staples, F. R., Cristol, A. H., Yorkston, N. J., & Whipple, K. (1975). *Psychotherapy versus behaviour therapy*. Cambridge, Massachusetts: Harvard University Press.
- Swift, J. K., Callahan, J. L., Heath, C. J., Herbert, G. L., & Levine, J. C. (2010). Applications of the psychotherapy phase model to clinically significant deterioration. *Psychotherapy: Theory, Research, Practice, Training*, 47, 235-248.
- Truax, C. B. (1963). Effective ingredients in psychotherapy. *Journal of Counselling Psychology*, 10, 256-263.
- Vandebos, G. R., & Karon, B. P. (1971). Pathogenesis: A new therapist personality dimension related to therapeutic effectiveness. *Journal of Personality Assessment*, 35, 252-260.
- Walfish, S., McAlister, B., O'Donnell, P., & Lambert, M. J. (2012). An investigation of self-assessment bias in mental health providers. *Psychological Reports*, 110, 639-644.
- Watzlawick, P., Weakland, J., & Fisch, R. (1974). *Change: Principles of problem formation and problem resolution*. New York: Norton.

- Werbart, A., Von Below, C., Brun, J., & Gunnarsdottir, H. (2015). "Spinning one's wheels": Nonimproved patients view their psychotherapy. *Psychotherapy Research*, 25, 546-564.
- White, M. M., Lambert, M. J., Ogles, B. M., McLaughlin, S. B., Bailey, R. J., & Tingey, K. M. (2015). Using the Assessment for Signal Clients as a feedback tool for reducing treatment failure. *Psychotherapy Research*, 25, 724-734.
- Whitehorn, J. C., & Betz, B. (1960). Further studies of the doctor as a crucial variable in the outcome of treatment with schizophrenic patients. *American Journal of Psychiatry*, 117, 215-223.
- Yalom, I. D., & Lieberman, M. A. (1971). A study of encounter group casualties. *Archives of General Psychiatry*, 25, 16-30.
- Youn, S. J., Kraus, D. R., Castonguay, L. G. (2012). The treatment outcome package: Facilitating practice and clinically relevant research. *Psychotherapy*, 49, 115-122.

Section B

A variable picture: A grounded theory analysis of the experience of therapy in the context of negative change

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Abstract

Background

Negative change occurring during psychological therapy is under-researched. There is currently no theory which unifies correlates identified by previous research.

Aims

This study aimed to generate a theory of negative change by interviewing clients and therapists about their experience of therapy when reliable score deterioration on outcome measures had been observed.

Method

In-depth interviews were conducted with eight clients and four therapists about the process of therapy. Analysis was based on a positivist Grounded Theory methodology.

Results

The emerging model identified three major themes postulated to explain negative change as experienced by this sample: a context of adversity, the therapeutic process and help withdrawn, within the context of positive outcomes. Process issues incorporated categories around: feeling there was not enough helpful advice, talking about distressing issues, difference, the challenge of no change, relationship difficulties, ambivalence, losing hope and goals around getting support instead of change.

Conclusion

The importance of paying attention to context and life events was highlighted. Many clients wanted further input and some did not think there had been a negative outcome, or noted that change was not instant. Varied process issues highlight the need to adjust interventions for clients and review outcome measures used.

Introduction

Any intervention seeking to induce change may result in both positive and negative outcomes. Although there is good evidence for the efficacy of psychotherapy, a small proportion of individuals consistently show evidence of a negative outcome following therapeutic input (Lambert, 2013). It is therefore important that outcome studies report negative outcomes or potential ‘side-effects’ alongside positive impact. Psychotherapy outcome research has frequently failed to do this and negative change occurring during the course of therapy may go unreported, or if reported, subject to little discussion or analysis (Jonsson, Alaie, Parling, & Arnberg, 2014; Nutt & Sharpe, 2008). This represents a missed opportunity to learn about negative change, the circumstances in which it is likely to occur and actions which might prevent such outcomes.

Definition

Negative change is defined as a process occurring during therapy, where a client’s experienced symptoms of distress appear to increase or worsen. This is usually established by comparing outcome measure scores from treatment outset to termination or follow-up. Researchers often consider a change of two standard deviations on an outcome measure score to represent a clinically significant increase in symptoms (Jacobson, Follette & Revenstorf, 1984).

Prevalence

Recent estimates of the prevalence of negative change state that around 3-15% of patients receiving psychotherapy may experience negative outcomes (Linden, 2013). However, not all services collect data consistently. In the UK around 6% of clients receiving therapy from Improving Access to Psychological Therapies (IAPT) services show evidence of reliable deterioration on outcome measures (Gyami, Shafran, Layard & Clark, 2013). IAPT is a

service which aims to administer outcome measures prior to every therapy session, collecting a vast quantity of outcome data. Interestingly, despite this, there remains very little research analysing negative outcomes in this setting.

Previous Research

The potential for negative outcomes in psychotherapy has been recorded and known about for many years (Bergin, 1963; Masserman & Carmichael, 1938). Historically therapists were taught to expect negative change in their practise although this is reportedly no longer the case in most training schools (Barlow, 2010). Literature reviews have identified lists of correlates which might be associated with negative change. These can broadly be divided into client, therapist and process factors. Client correlates include factors such as a Borderline Personality Organisation, Obsessive-Compulsive traits, panic, poor motivation, expecting therapy to be painless, severe interpersonal problems, initial high symptom severity, chronic conditions, multiple previous therapies, comorbidity, being single and being less educated. Therapist factors include low levels of empathy and warmth, underestimating client issues, poor technique, high numbers of transference interpretations and disagreement with the client (Lambert, Bergin & Collins, 1997; Mohr, 1995). However, studies cited often have methodological limitations and were conducted many years ago, when therapy might have been different to current interventions.

Current knowledge

Michael Lambert and his colleagues have written extensively about negative change, in terms of how best to detect and measure this, also proposing methods which may help reduce its occurrence (Lambert & Bergin, 1994; Lambert, Whipple, Bishop et al., 2002; Lambert, Whipple, Smart, Vermeersch, Nielsen & Hawkins, 2001). A call for clinicians to obtain feedback by routinely monitoring patient outcome (Lambert et al., 2003) came from research

suggesting that therapists are not good at detecting negative change in their clients, perhaps due to a bias of having an overly positive view of their own work (Walfish, McAlister, O'Donnell & Lambert, 2012). Hatfield, McCullough, Frantz and Kreiger (2010) investigated therapists' ability to notice negative change and make treatment decisions on the basis of this. According to clinical notes there was little evidence that therapists noticed negative change and in around half of cases, they appeared to continue treatment as usual.

A recent study (Probst, Lambert, Loew, Dahlbender, Gollner & Tritt 2015) looked at expected recovery curves according to the Outcome Questionnaire Analyst (Lambert, 2012) and identified clients who showed extreme positive (EPD) or extreme negative (END) deviations. The researchers then looked for correlates and found that less social support and negative life events were associated with negative change. These results suggest that clients in the study did not do badly as a consequence of therapy and that interventions should target the social structure and support around clients if possible. However, the authors only examined four potential correlates; motivation, therapeutic alliance, social support and life events. Other factors could have been correlated with negative outcomes had they been included.

The client's experience

Therapists and clients may have different views about what change is desired. For example, Watzlawick, Weakland and Fisch (1974) suggested that long-term therapy aims to achieve unattainable or utopian goals, valued by the therapist more than the client and potentially leading to client resistance. Fago (1980) found that therapists tended to rate clients receiving long-term therapy as improved, whereas client's scores showed the opposite pattern, suggesting that therapists' and clients' views about desirable change may differ. These

studies stress the importance of obtaining the client's viewpoint when investigating negative change.

Prior research has informed us about correlates of negative change occurring during routine clinical practice (Probst, Lambert, Loew, Dahlbender, Reiner & Tritt, 2015; White, Lambert, Ogles, McLaughlin, Bailey & Tingey, 2015). Some studies have also collected data about therapist explanations of negative change (Bystedt, Rozental, Andersson, Boettcher & Carlbring, 2014; Shepherd, Evans, Cobb & Ghossain, 2012). However, few studies explore the clients' experience, beyond using outcome measures; and it would be useful to know more about this. Firstly, this could help to identify instances of negative change attributable to the therapeutic process as opposed to negative life events, a greater awareness of symptoms, or a process whereby the therapy resulted in improvement (because without therapy the deterioration would have been greater). Secondly, it would be hoped to generate insights not previously identified, leading to novel suggestions for preventing the occurrence of negative change.

A study by Werbart, Von-Below, Brun and Gunnarsdottir (2015) carried out in Sweden, is one exception. They interviewed 20 patients who received psychoanalytic therapy and were defined as 'non-improved', including both those who had experienced no change and those who experienced score deterioration according to outcome measures. Although participants reported some positive experiences, a core category named 'spinning one's wheels' emerged from the data, which described therapy as an ongoing process that resulted in no movement towards goals. Participants described concerns around not understanding the therapeutic method, therapy being too short or insufficient, experiencing distance in the therapeutic relationship and a focus on past experiences, when a focus on the present or future would have been valued more.

A potential limitation is that the authors combined patients experiencing no change and negative change when research has suggested that these might be qualitatively different (Mohr et al., 1990). However, there is debate around this. Some categories which emerged might also be specific to psychoanalytic therapy, for example, problems related to focussing on the past might not be expected for clients who receive CBT or counselling. It would be useful to know if similar themes emerge for clients receiving input from IAPT services, which provide mostly counselling and CBT interventions, or if similar themes emerge when only clients who deteriorated are included. It might also be expected that services such as IAPT would be especially focussed on negative change and be working proactively to intervene. This is because outcome measures are administered as standard before each therapy session within IAPT and therapists can access graphs of their clients' progress at any point.

Rationale for the current study

Despite having theories about positive change (Prochaska & DiClemente, 1984; Ryan & Deci, 2000), there is not yet an integrated theory attempting to explain negative change. Theories about positive change postulated on the basis of previous research and theory should include aspects such as a positive, collaborative therapeutic relationship, readiness to change, intrinsic motivation, optimism and accepting responsibility for one's own recovery (Rotter, 1966). But it is not clear whether a theory of negative change would be the opposite or absence of the aforementioned features or if it would involve other, previously unconsidered factors or processes.

Lambert's Clinical Support Tools (CSTs; Lambert, Bailey, White, Tingey & Stevens, 2015) provide the most helpful contribution yet towards identifying a theory of negative change, since in the event of any deterioration, he devised an outcome measure (Assessment for

Signal Cases, ASC), which looks for problems in four key areas: the therapeutic alliance, social support, motivation, and stressful life events. The CST manual provides advice for action in each of the four areas. For example, if therapeutic alliance is indicated, the therapist should aim to ensure they have the same goals or ask for client feedback; whereas if motivation is implicated, questions based on Miller and Rollnick's (2002) motivational interviewing techniques are advised. Although research around CSTs is still in process, they appear to have been devised based on evidence related to positive change or out-dated research on negative change. Increasing current knowledge of negative change in various clinical settings could help to improve such tools.

This current review only identified one previous study investigating correlates of negative change within an IAPT service. Branson, Shafran and Miles (2015) conducted a naturalistic study of trainee therapists delivering a CBT intervention within an IAPT training service. However, they only looked for a correlation between therapist competence and client outcome. They found no correlation but when therapists were divided into three groups according to competence, clients treated by the least competent therapists showed a higher than expected rate of deterioration in their symptoms. Although this is useful to know for clinician training, it does little to inform us about negative change occurring with trained therapists.

This study aims to generate a theory about the factors contributing to negative change in brief therapy. Since this theory is hoped to provide a general explanation of negative change rather than a modality specific one, all individual therapy occurring within the relevant service will be of interest. Previous research investigating negative change has usually been quantitative (Barlow, 2010) and although Shepherd et al. (2012) carried out a qualitative study, this provided no specific suggestions to improve practice, as therapists did not attribute negative change to themselves. This study will add the richness of qualitative data to the therapeutic

change evidence base by exploring how clients and therapists experienced the process of therapy in the context of negative change. Previous research has highlighted the gap in the evidence base in terms of including service user perspectives, however; therapists' perspectives may be important to add additional information and provide clarification or perhaps an alternative view of the therapy. Including both perspectives is therefore hoped to improve the validity of the theory. In light of recent attention around the paucity of research into negative outcomes following therapy, it is timely to explore this issue, with the hope of providing recommendations to improve client care across services.

Research questions

- When negative change is indicated by measures after brief psychological therapy, what aspects of the client's or therapist's experience might help to explain this?
- What factors might a theory of negative change include?

Methodology

Participants

Twenty-seven clients of a metropolitan IAPT service were identified as having reliably deteriorated according to scores on the Generalised Anxiety Disorder measure (GAD-7), the Patient Health Questionnaire (PHQ-9) or both, following psychological input in 2014-2015. Fifteen had received Cognitive-Behavioural Therapy and 12 had received counselling. Ten therapists provided the CBT intervention and all were female. Nine counsellors, of which three were male and six were female, had provided the counselling. Clients had received between 5 and 25 sessions, with a mean of 10 sessions. Table 2 shows details of this study's participants.

Table 3: Participant information

Participants (Male = M Female = F)	Therapist or client	Age of client	Intervention type	Sessions attended	Sessions DNA	Sessions cancelled by client	Ethnicity of client	GAD-7 or PHQ- 9 deterioration
1- 'Sandy' (F)	Client	58	CBT	19	0	1	White British	PHQ-9
2 - 'Patrick' (M)	Client	59	CBT	15	2	0	White British	GAD-7
3 - 'Katrina' (F)	Counselling psychologist	33	CBT	10	1	6	Other	Both
4 - 'Mehmet' (M)	Client	52	Counselling	10			Algerian	GAD-7
5 - 'Rosie' (F)	Trainee Clinical Psychologist	41	CBT	6	5	2	White other	PHQ-9
6 - 'Constance' (F)	Client	60	Counselling	7	1	1	Black Caribbean	PHQ-9
7 - 'Amber' (F)	Client	38	CBT	6	3	1	White British	GAD-7
8 - 'Rachel' (F) worked with Patrick	Clinical Psychologist	59	CBT	15	2	0	White British	GAD-7
9 - 'Amy' (F)	Client	48	CBT	7	0	4	Asian other	PHQ-9
10 - James (M)	Client	25	Counselling	8	1	1	White British	PHQ-9
11 - 'Olive' (F)	Client	55	Counselling	8	2	1	Greek other	Both
12 - 'Carl' (M)	Counsellor	31	Counselling	10	0	3	White other	GAD-7

Ethics

This study was reviewed and given a favourable opinion by a National Research Ethics Service Committee (see appendix K).

Design

This was a non-experimental qualitative design. Individual interviews were analysed using a Straussian grounded theory methodology (Corbin & Strauss, 2008) to build a theory of negative change.

Measures

Two different semi-structured interview schedules were used with clients and therapists (see Appendix H). The client interview schedule contained four question categories which asked how the client found out about IAPT, how they experienced therapy, how they experienced the IAPT therapist and how the treatment impacted on their life. The therapist interview schedule contained four question categories which asked how the client came to IAPT, what the experience of therapy was like, what their experience of working with the client was like and what the outcome of therapy was. Each question category contained a number of prompt questions to ask the interviewee if necessary. As this was a grounded theory design some questions were added or modified as the study progressed.

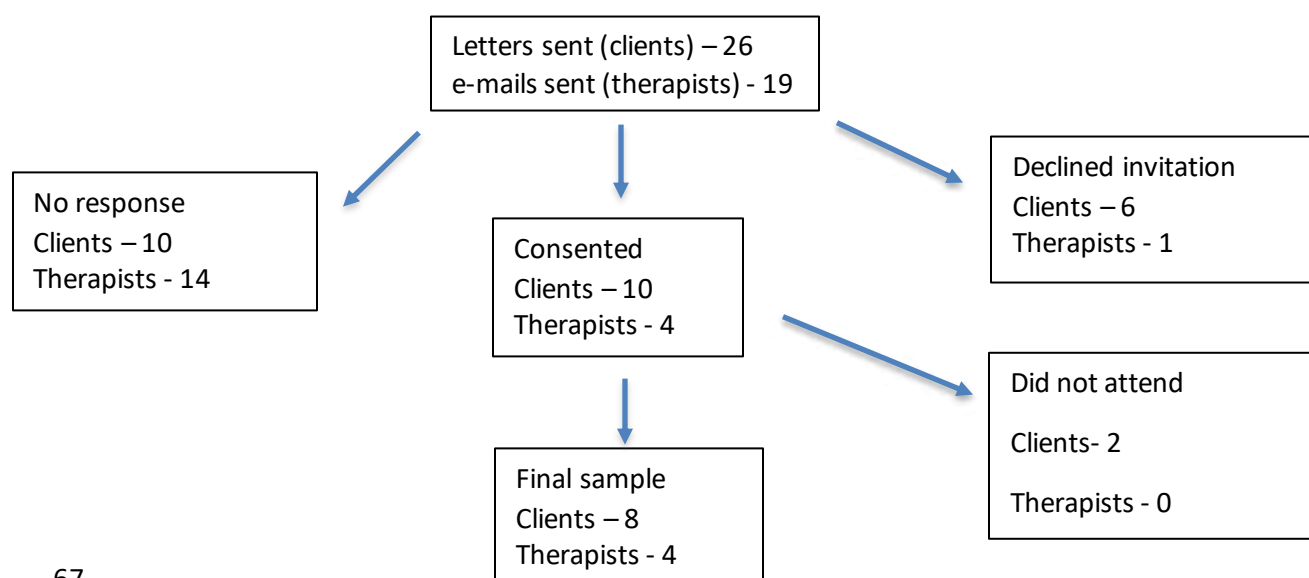
Score deterioration was calculated on the basis of GAD-7 or PHQ-9 scores. The GAD-7 is a 7 item self-report measure which screens for anxiety using 4 point Likert-type scales (Spitzer, Kranke, Williams & Lowe, 2006). The PHQ-9 is a 9 item self-report measure which screens for depression using 4 point Likert-type scales (Kroenke, Spitzer & Williams, 2001). Both measures ask patients to rate how much they have experienced symptoms in the past two

weeks. For the purpose of this study, reliable deterioration was defined as an increase of at least four points on the GAD-7 or at least 6 points on the PHQ-9 (IAPT, nd).

Procedure

Twenty-six clients identified as having experienced score deterioration were sent letters inviting them to participate in the study (See Appendix A), along with an information sheet (see Appendix B), a return slip to accept or decline and a stamped addressed envelope. One client was excluded and not contacted since she was still engaged in therapy. The letter informed participants about the study and mentioned that they would be telephoned once if no response was received. If clients consented to take part they were offered an appointment at a local IAPT base or their home, depending on their preference and mobility. Therapists were contacted by email and received a separate information sheet (see Appendix E). At the appointment participants were given the information sheet to read again and had an opportunity to ask questions before they completed consent forms (See Appendix F). If consent was given they took part in an interview which lasted up to one hour using questions from the relevant interview schedule. Twelve individual interviews were conducted and all were audio-recorded. After interview recordings were transcribed and coded using MAX-QDA.

Figure 2: Flow chart of sampling process



Data Analysis

Analysis was carried out according to the Corbin and Strauss (2008) method of grounded theory, based upon a positivist epistemology. This was thought appropriate since this study attempted to identify a theory of negative change which would inform research and clinical practice around potential correlates and ways to prevent or minimise its occurrence.

Transcribing and coding of interview data was carried out alongside interviewing as far as was possible. Memo-writing was used to stimulate the researcher's thinking process around analysis and to have a record of these processes. Process notes were recorded after interviews and as the study progressed, to brainstorm about salient impressions of participants and reflect on these in relation to personal biases or prior knowledge (See Appendix J). After coding five interviews on a line by line basis, a spider diagram of all emerging themes was drawn out, which helped to identify concepts and categories or themes. Themes which needed confirmation or would benefit from further information were noted, which informed additions to the interview schedule. After all interviews had been transcribed, diagrams were drawn for each person, highlighting key themes relating to their experience of therapy and in particular, themes which might help to explain negative change. Diagrams were then analysed to generate hypotheses about the negative change which had been identified on the outcome measures. Following the use of diagrams, transcripts were recoded and analysed to clarify themes and concepts by 'continuous dialogue' with the data (Becker, 1998).

Quality Assurance

Guest, Bunce and Johnson (2006) proposed that 12 interviews should be adequate to reach theory saturation, so this study aimed to recruit 12 participants. No new themes central to the model emerged at the 12th interview.

A bracketing interview (Rolls & Relf, 2006) which lasted around 40 minutes was carried out by a colleague of the principal investigator. This explored the principal investigator's preconceived ideas, predictions and expectations about the project (see Appendix I).

Verbatim quotes were used in support of the final model. Supervision and meetings with supervisors were used concurrently with data collection to discuss coding and interpretation of the interview data.

A section of one interview was cross-coded by a colleague of the principal investigator in order to validate emerging themes. Agreement was found to be 87.5% (see Appendix M).

Results

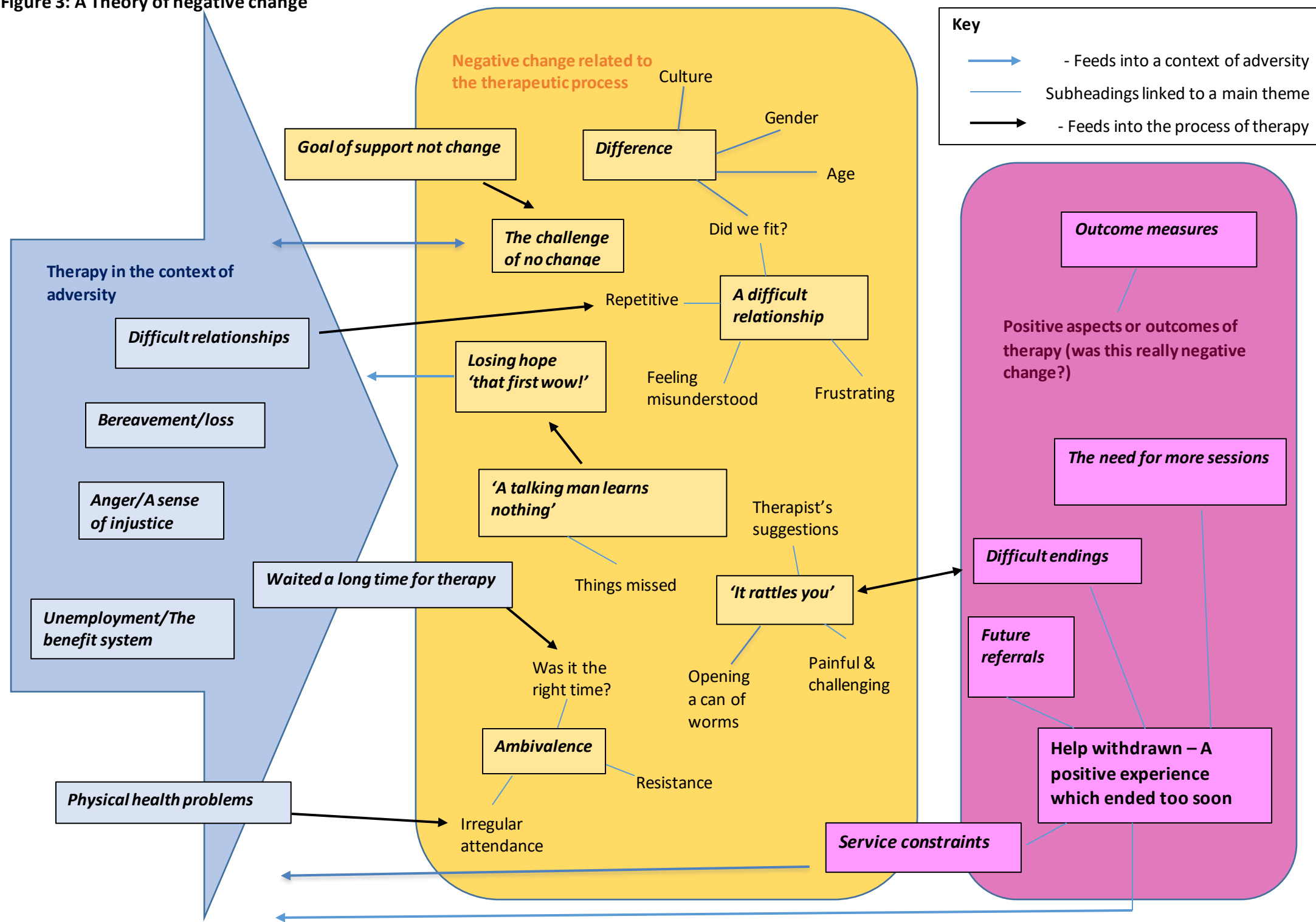
Analysis identified 635 coded segments and major categories emerged, offering potential explanations for the phenomenon of negative change seen in this sample. The categories included:

- Therapy in the context of adversity. Descriptions of negative life events or hardships proposed to reduce the effectiveness of therapy.
- Negative change related to the therapeutic process. Aspects of therapy that clients or therapists found difficult or did not seem effective.
- Help withdrawn: Therapy described as a positive experience overall, raising questions around whether therapy had ended well, or before the client had fully benefitted.

Figure 3 shows these categories included in a model of negative change.

The model indicates firstly that clients might come from a context of adversity. Participants spoke about returning to this context after therapy sessions; going back to difficult relationships, unjust situations and struggling with unemployment and the benefit system. However, there were also clear examples of clients experiencing increased adversity or negative life events during the course of therapy. This context was said to impact on the process of therapy, such that difficult circumstances affected with how well people could engage with therapy, they impacted on mood, potentially leading to increased levels of depression and anxiety and they seemed associated with the aim of just wanting support; not expecting that change could be possible. Experiences of the therapeutic process also included negative experiences that could help to explain negative change. However, positive experiences or outcomes, suggesting that either the client did not feel worse or only experienced feeling worse as a result of therapy ending too soon or perhaps the ending not being dealt with appropriately (Help withdrawn) were also reported.

Figure 3: A Theory of negative change



The following section describes coded sections which emerged but were not central to the theory. These have been used to describe and situate clients in terms of context, including their characteristics, the referral and reported difficulties at the time of referral. Peripheral discussions of negative change are also described.

Context

Ten interviewees described issues relating to depression, which might be expected within an IAPT service, primarily working with symptoms of anxiety or depression. Other presenting issues or difficulties were described as: being self-critical, sleep difficulties, suicidality, risk to others, lack of confidence, being unable to accept feelings, working too hard, drinking too much alcohol, feeling trapped, Autism Spectrum Disorder, feeling dissociated, high levels of anxiety, adjustment disorder and trust issues. Factors describing people's characteristics included: perfectionism, being difficult, being self-aware, having an interest in psychology and openness. Two clients described having supportive family members.

Four clients talked about having been prescribed medication. Some reported that they had been taking medication for years, others said that they took it inconsistently. One person reported that the medication was helpful, although initial side-effects could be difficult to cope with. Another person reported that she had been taking medication but her depression still became worse.

In terms of the referral, most reported being referred through their GP, although one participant mentioned an advisor at the jobcentre suggesting therapy. Some people made their own decisions about needing therapeutic input, whereas others mentioned close friends or family members persuading them.

Negative change

Some themes emerged describing the response to negative change as opposed to attempting to explain it. Therapists described feeling disappointed or sad when they observed negative change. However, it was also described as natural and to be expected. All therapists felt it was an important issue to investigate, although concerns were raised around political context meaning that findings could be used to reduce funding or exclude some people from the offer of therapy. Other concerns raised included the temptation to falsify data if services are being commissioned according to outcome scores, or therapists feeling judged, criticised or inadequate.

Central themes

The following section outlines the three central themes thought to contribute to a theory of negative change, with verbatim quotes. (All quotes are ascribed to falsified names to protect participant identities.)

Therapy in the context of adversity

Concepts under this heading included negative life events occurring while therapy was ongoing and negative circumstances which impacted on how effective therapy could be. Included within the negative life events were bereavements, family conflict and being made homeless. The negative circumstances included factors such as chronic pain, ongoing grief, a sense of injustice and anger or circumstances around the individual such as family conflict, difficult relationships or unemployment and the way people were treated by the benefit system. This feeling of adversity could have increased due to the feeling of needing further support, addressed later in the theme 'help withdrawn'. It also feeds into the therapeutic process, influencing the loss of hope and irregular attendance. The challenge of no change is also thought to be linked to a further loss of hope and associated feelings of adversity.

Bereavement/loss

Some bereavements occurred alongside therapy, while other clients seemed to be experiencing unresolved grief.

‘After the first session her.. mother in law... had gone into hospital for lung cancer... and then... I can’t remember if it was the 2nd or third session, she actually died.’ (Rosie, therapist)

Quotes such as the above seemed to provide an intuitive explanation for an increase in symptoms.

Difficult relationships

There were many descriptions of difficult relationships outside of therapy, most often with family members, particularly when clients had taken up a caring role. However, sometimes they referred to other people, for example, friends or nannies. Clients often described therapy is not able to help with these issues as they seemed to be outside of their control. In the model, difficult relationships are proposed to link into process issues since they may represent a difficulty with relationships in general, thus impacted on the therapeutic alliance.

‘My girlfriend... she’s been hiding so many stuff... from me, and I found out... and then when I wanted... to finish with her, she said to me to kill herself. And she tried this, in front of me, she cut her vein...’ (Mehmet)

‘the other nanny was interfering too much, she’s too mouthy... I tell her to stop shouting’ (Amy)

Physical health problems

Physical health problems such as those related to pregnancy, chronic pain and even memory problems impacted on the ability to attend, engage with and benefit from therapy sessions.

‘I was missing a lot of the sessions... I was ill all the time... I was in hospital in and out, in and out...’ (Amy)

Interviewer: ‘Was it helpful?’

Constance: ‘No I wouldn’t say... because right now I be talking to you and if, things that I want to say... I forget... I do forget it now and... later... it just come to me’

Anger/A sense of injustice

Some clients described high levels of anger, which could seem justified in view of events they had been facing. Therapists sometimes described this anger as something that kept the person stuck and unable to move on or change.

‘There’s only so much that could’ve shifted because... he wanted an apology... a resolution, he wanted someone to say... it’s not your fault... I had a strong feeling that, if he had got that... he could’ve moved on’ (Katrina, therapist)

Unemployment/The benefit system

Being unemployed could be depressing in itself, but some participants described an additional layer of distress attributed to the benefit system. It seemed that some clients felt they were treated as not good enough or as though they should feel guilty for not working.

‘You have to go to this work programme thing where instead of looking for jobs at home... you have to go and sit... with a load of other people and you got to sign in and out 3 times a day and you can’t go home cos if you do you get sanctioned... they treat you like... naughty schoolchildren and.. as if you’re all benefit scroungers and... I find it, firstly very offensive... The way they treat you when you’re on benefits could be calculated to drive somebody into depression.’ (Sandy)

In this model, the context of adversity meant that whilst therapy aimed to improve functioning, circumstances often resulted in increased levels of distress. Negative life events such as bereavement could explain an increase in symptoms whereas ongoing negative circumstances could lead to hopelessness and the belief that things could not change.

Goals of support

The theme ‘goal of support not change’ straddles this context and process factors because the experience of adversity seems linked. Sometimes it seemed that the clients’ goals were around getting support or a space to talk rather than the expectation that anything was going to change. These goals may have affected their motivation and decreased the likelihood of positive change.

‘It was support it wasn’t anything changing my life... there was too much going on to change anything’ (Amy)

Waited a long time for therapy

The other theme which straddles these major themes is waiting a long time for therapy, which might be a factor contributing to the experience of adversity. However, while some clients may have felt worse due to this, others described it as meaning that they already felt better when therapy started. This may have an impact on the direction of change seen on the measures.

Negative change related to the therapeutic process

‘A talking man learns nothing’

This theme emerged from six of the interviews. Participants spoke about feeling like talking could not help, expecting to get more input or coping ‘tools’ from the therapist or therapy

raising more questions than answers. One person felt that he needed something more than counselling and would have liked to speak to someone 'more professional'.

'A talking man learns nothing... If I'm listening then I'm learning, if I'm talking, I'm not learning and who's the one that's learning?' (Patrick)

'He was listening yeah but... he didn't give me any tools to even... give me anything to fight with' (Mehmet)

These experiences were postulated to lead to a loss of hope and disappointment with therapy as described in the next theme.

Losing hope 'that first wow!'

Three participants described experiencing an initial boost, moments of insight and hope followed by disappointment;

'If she can change my way of thinking, then... this is gonna be amazing... And that was the one and only time that she said something... that made a lot of sense and it never came again... At the end of the day the experience as a whole was a bit of a disappointment' (Patrick)

Or not being able to maintain changes;

'The first week I did really well on it and I thought, 'this is it, I'm sorted' and then it... slipped back and I did get very despondent' (Sandy)

In these cases negative change could therefore be linked to disappointment and an associated increase in symptoms.

'It rattles you'

Eight interviews described challenges around therapy being difficult, although most thought it had still been useful. Participants described difficulties with being honest, feeling

vulnerable, bringing up issues from the past and therapy leaving them feeling less able to function. Feeling less able to function is probably dependant on social support in terms of how problematic this was; if others were available to help it might have felt more acceptable. Some participants reported that therapists could also suggest problems to clients, leaving them feeling paranoid after the sessions.

‘It rattles you doesn’t it... I’d maybe go there in quite a good mood and then I’d leave and I was, my day was kind of... dead... Cos you do uncover a lot of things and you talk about things that are probably more sensitive than you realise’ (James)

‘It was difficult yeah because... I was bringing things up, from years ago and, I was thinking, god, I’m opening a can of worms!’ (Olive)

‘It’s... overwhelming and... very, very hurt... it hurts when you talk about it’ (Mehmet)

Difference

Some clients and therapists mentioned issues of difference which may have affected the outcome of therapy. These included differences related to age, gender and culture. The below quote provides an example of the issue around age difference;

‘She was much younger than me, I’d sooner somebody... that’s older... cos when we are younger we do not understand much... when we mature, we understand’ (Constance)

A difficult relationship

Some difficulties with the therapeutic relationship were noted. Clients sometimes felt misunderstood, or therapists described a lack of empathy;

‘Intellectually, I had... roughly the same understanding, but emotionally I couldn’t get to grips with what the issues were’ (Jane, therapist)

Sometimes there were feelings of hopelessness;

‘I wondered whether I was feeling a little bit hopeless for him and... I hope he didn’t pick up on that’ (Katrina, therapist)

Or feelings that the therapist was critical, too directive or repetitive;

‘She was giving me... lots of answers back, I didn’t really like; ‘this is what.. you should do’ or ‘do that’’ (Amy)

‘She mentioned it quite a few times in quite a few of the sessions, she always said the same things’ (Patrick)

Ambivalence

Sometimes clients seemed unsure what they wanted in terms of their goals or the type of therapy they had. Irregular attendance was also talked about as something that might have indicated ambivalence and therapists sometimes wondered if it had been the right time for therapy.

‘I couldn’t understand how therapy was gonna change things’ (Patrick)

‘Towards the end of the therapy there were... patterns of irregular attendance, cancellations.... I did... wonder what was happening... I thought is there anything that I’m not... contributing as a therapist? What is he trying to communicate?’ (Katrina, therapist)

The challenge of no change

This theme emerged often when discussing change. Participants might say that there had been no positive change but no negative change either. Some described feeling stuck or trapped, while others suggested that change might not have happened until sometime after therapy.

‘He openly acknowledged his anger... his depression, he just felt that he couldn’t move on and I, think I felt a little bit like that with him’ (Katrina, therapist)

‘It took a while to sink in... cos you gotta remember... you’re talking about how many years, you’re blaming yourself and everything’ (Olive)

The latter quote suggests that if followed up after therapy, some clients scores may have altered to show improvement.

Positive aspects or outcomes of therapy

This category contained 127 sub concepts, as clients listed many aspects which they found useful about therapy. Coded sections describe positive relationships with the therapist, receiving practical advice and an appreciation of having somewhere to talk which felt confidential, non-judgemental and objective. Many clients also appreciated the type of input they received and the changes it helped them to make. The emergence of so many positive aspects may seem paradoxical in the context of an investigation of negative change. Due to this, outcome measures are also discussed in relation to this, raising the question of whether participants really did experience negative change overall.

Outcome measures

Outcome measures were described as useful but sometimes criticised for not picking up on the whole story or being less important than what was spoken about in therapy. One therapist felt that outcome measures caused clients to be reminded of previous symptoms rather than looking to the future or thinking about positive change. One client also described finding it difficult to rate levels of symptoms on the measure. These descriptions suggest that clinicians did not always believe that the measures used had picked up on the full story. In terms of usefulness, therapists described avoiding looking at scores and one therapist said she did not discuss scores with a client because they were showing negative change and she felt

this might be unhelpful. Two therapists raised concerns about being too driven by outcome measure scores and ‘looking for a nice decline’.

Help withdrawn

This is a major category which may help to explain why so many positive aspects of therapy were described in a study of negative change. Subcategories include difficult endings, future referrals and the need for more sessions. The title of this category comes directly from the words of a client (Sandy). Except for in cases where future referrals were made, help withdrawn too early may have fed back into an experience of adversity.

Difficult endings

Both session endings and the end of the therapy were sometimes described as difficult. In some cases it seems like endings could have been discussed or addressed more fully and in this way, might link back into process factors in the model.

‘It was a tricky conversation and he... didn’t want to leave, so it’s one of those... ‘right, well... you take care and good luck and... bye!’ and... he was just still sitting in the chair, so having to try and physically get him up’ (Anne, therapist)

In other cases clients reported the ending coming too soon;

‘You’re not properly better, it’s like stopping the tablets when you’re still poorly, I mean... it was very helpful... but, it would have been so much more helpful if we could of continued or, I was at a stage that I could carry on better’ (Rachel)

Service constraints

Therapists sometimes said they felt restricted and unable to offer more sessions even though they thought this could be useful in view of the severity or chronicity of client’s issues. As seen in Figure 3, these constraints feedback the process of therapy.

‘The service has some really rigid, well I think it’s rigid; had they not had those requirements I think I would’ve extended the sessions... I probably would of offered him 16-20 sessions’ (Katrina, therapist)

Future referrals

Some clients were referred for other input, or were told about other services with the option to self-refer, but this did not always end successfully.

‘I did refer him on... the CMHT... ultimately wouldn’t accept him... he didn’t get any further support but he wasn’t in a place where he could use an IAPT intervention either’ (Anne, therapist)

‘She didn’t leave me out in the cold which she could of... she was good to refer me on’ (Amy)

The need for more sessions

The theme around needing more input emerged from seven of the interviews and was mentioned by clients and therapists.

‘It wasn’t enough... she would of benefitted from... longer term therapy’ (Carl, therapist)

‘I mean this... 8 weeks is... is not enough... Between 8 weeks and err something for, 25 years... or more than that’ (Mehmet)

In this model, help withdrawn contributes to the explanation of negative change by presenting aspects of the experience of therapy which felt unfinished. The disappointment or distress felt in the context of a positive experience ending before the client is ready, could potentially account for symptom increase seen on the measures at the last session.

Discussion

This study explored client and therapist experiences of therapy within an IAPT service, when there was evidence of negative change according to outcome measures. The following section will discuss the main findings of the emerging model, keeping in mind previous research and how findings might be applied to current practise.

Therapy in the context of adversity

Sometimes when clients described many difficulties they were still coping with at interview, the expectation that short-term therapy could achieve positive change seemed optimistic. Some had been depressed for many years, were unemployed and not in receipt of benefits they were entitled to, were facing uncertainty in terms of their living situation, lacked social support, suffered from chronic physical health problems, including chronic pain and had experienced various bereavements and losses.

However, those who were angry with a strong sense of injustice seemed to pose a particular challenge. Their sense of injustice seemed understandable both to myself and to their therapists. Events including loss, injustice, divorce, infidelity, losing contact with children and lending large sums of money which were never returned, proved difficult for some clients to accept. Therapists spoke about how such acceptance, or perhaps adjustment, would be necessary for the client to move on, but this seemed impossible to achieve at the time. These results tie in with the Probst et al. (2015) findings suggesting that negative outcomes were associated with client circumstances and were not a consequence of therapy.

It is also important to consider clients' expectations of what therapy can achieve. Some were referred via their GP with little explanation about what the process would entail. It's possible that some were not aware of the effort therapy would demand and hoped it would provide a cure, which would be administered to them. Clients facing severe adversity may have

benefitted from a different type of intervention, targeting social support and structure around them, such as group work with similar others (Thoits, Kazdin & Heller, 1986) or a service working more assertively with social circumstances. However, as one therapist pointed out, due to various cuts to services, it can sometimes be difficult or impossible to provide this.

Cited issues with the benefit system and associated feelings of guilt and further depression, merit consideration when thinking about the context. Some have criticised IAPT's agenda of getting people back to work as something which interferes with the ability to form a good therapeutic alliance (Wesson & Gould, 2010), stating that the relationship may not be genuinely collaborative if the therapist is influenced by these service expectations. The experience of this agenda may also cause the client to feel guilty and worthless if they remain on benefits. As one participant stated, the current benefit system could be 'calculated to drive people into depression' and if therapeutic services are perceived to be aligned with this, it could be unhelpful. However, this is speculative and was not specifically referred to by participants in this study.

Negative change related to the therapeutic process

Factors emerging in this part of the model varied greatly between participants. Some felt that talking did not help, whereas others had only wanted support and found advice unhelpful. Some found the relationship difficult and others found it challenging to bring up past issues or to be honest with the therapist. Others may have held unrealistic expectations for therapy or described an initial boost which was not maintained. Difference in the therapeutic relationship was also cited as an issue, influencing how understood the client felt. The uncertainty of seeing no change could also be difficult, perhaps reflected in, or influenced by, the ambivalence of some clients.

Although the theme ‘A talking man learns nothing’ arose from interviews with both male and female participants, it seemed to emerge more often from men as something they struggled with. It could be that the process of talking about emotions is more difficult for men (Pollack & Levant, 2008), although one study found that men show an equal preference for psychotherapy over medication when compared with women (Sierra Hernandez, Oliffe, Joyce, Söchting & Ogrodniczuk, 2014). One male participant went on to join a group called ‘men in sheds’ which seemed to offer a more favourable type of input for him. However, it was not only a problem for men, one woman also found it difficult to see how she could benefit from just ‘her alone talking’. Since she also mentioned the problem of an age difference, it could have been that she felt the therapist was not knowledgeable enough or could not offer solutions. In her words, ‘when we are young, we do not know much’.

Difficulty with the relationship is something previous research postulates as influencing the process of negative change and has been attributed to low levels of therapist empathy or an interaction of this with certain client characteristics (Lambert, Bergin & Collins, 1977; Truax, 1963). However, difference of opinion over the process of therapy and a greater number of transference interpretations have also been implicated (Mohr, 1995). Issues raised in this study related to not getting on, feeling misunderstood, feeling that the therapist was too repetitive, things being missed and frustration on behalf of both client and therapist. One therapist also spoke about her difficulty in finding empathy with a client. These findings support Lambert’s therapeutic alliance factor on CSTs, as being something important for therapeutic outcome.

The theme ‘It rattles you’ often referred to talking about difficult subjects and how this could be upsetting, but one client also raised the issue of therapists suggesting there are problems which the client has never considered. This may tie in with past research about therapists interpreting the transference too much or suggesting problems (Mohr, 1995). In terms of

negative change, the client might leave therapy with more worries, as opposed to feeling their existing symptoms have improved.

Therapists sometimes questioned whether it was the right time for therapy, a theory which echoed previous research (Shepherd et al., 2012). However, clients never mentioned this, perhaps feeling that therapy should provide support at difficult times, as reflected in the theme ‘the goal of support not change’. This might demonstrate a difference of ideas between clients and therapists on what therapy should provide, which could be addressed more fully at the outset of treatment (Daniels, 2011). Clients who received CBT or counselling both raised the theme of just wanting support or a space to offload and it’s interesting to note that the goal of counselling according to the service also seemed about achieving specific symptom change, whereas counselling might be more often thought of as something which would provide support without the emphasis on such specific goals (NHS Choices, 2015).

Positive experiences: Help withdrawn

Many clients reported having a positive experience of therapy and some stated that they had volunteered to participate in the study to give positive feedback. This did not seem to fit with negative change as seen on the outcome measures, but was consistent with statements about helpful input being withdrawn too soon. Both clients and some therapists talked about whether it could have been useful to have more sessions and this seemed to be a dilemma for therapists at times given service constraints. This finding echoes the results of Falkenstrom, Grant, Broberg and Sandell (2007), where three clients who did not benefit from therapy seemed to have a sense that it was ‘abruptly terminated’ or unfinished. It has also been postulated as a factor which mediates poor results with trainee therapists (Callahan, Aubuchon-Endsley, Borja & Swift, 2009).

The IAPT service offers time-limited therapy and attempts to be as cost effective as possible, but sometimes the use of such brief interventions has been questioned (Salzer, 2002). It can be difficult to justify providing more sessions if an intervention is not thought to be working though, and Waller (2009) cautions about persisting with therapy in these cases. However, if negative change is due to social adversity or life-events it might not seem appropriate to withdraw support, although a different type of input might be advisable (Lambert, Bailey et al., 2015). If clients only sought support and were not expecting change, this calls into question the service's rationale in looking for score decreases on outcome measures which do not collect information about client circumstances. Not all clients wanted more sessions, but those who did had often experienced chronic problems, ongoing for many years. In addition to help being withdrawn, some felt they needed something more in-depth than counselling.

Study limitations

There was a relatively short time period available for data collection, which limited the ability to implement theoretical sampling or to analyse interviews in full before proceeding. Ethical approval also limited the ability to change items on the interview schedule much, as specific schedules were approved. However, some theoretical sampling was applied, particular in seeking out male counsellors, since this was an unrepresented viewpoint. Although supervision was sought throughout analysis, more discussion around emerging themes could have been useful in validating the results. The principal investigator was also a novice at using the Grounded Theory methodology. Due to this, advice was sought from expert grounded theory researchers and the Corbin and Strauss text was followed as closely as possible. However, memo-writing and discussion around emerging themes may have been less in depth than those utilised by more experienced researchers.

The model of negative change was potentially also limited by the level of insight participants had into whether negative change had occurred and the reasons behind this. However, it would be difficult to find an objective measure, although analysing therapy transcripts or gathering data from additional measures, could be helpful. The model is also solely based on correlations, so it is not possible to know if negative change was the outcome or cause of certain process factors. For example, therapeutic alliance may have suffered as a result of negative change, rather than being difficult from the outset.

Ethical issues

It was recognised that talking about therapy which may not have been effective might be distressing for some and some participants did become upset at interview. One client in particular seemed to still be experiencing distress and was helped to re-refer via his GP. These concerns prevented the researcher from speaking about the negative change observed on the outcome measures with clients, in case this caused further upset. However, it would have been interesting to see if clients would have spoken more openly about problems if they knew about this finding. Some seemed reluctant to speak about problems and it was felt that they might be concerned that it would make the therapist look bad or be fed back to them. This may also reflect a general reluctance to complain, particularly in view of the fact that they had been offered input which most seemed very grateful for.

Clinical recommendations

As mentioned previously, IAPT services use outcome measures regularly and routinely in order to track progress. However, since the measures are highly symptom focussed and do not ask about life events, social adversity or interpersonal relationships, it may be difficult to detect negative change which is due to therapeutic process. If information was collected, using a measure such as the Outcome Questionnaire (Lambert, Morton et al., 2004), more

factors would be taken into account, which may also help to identify clients for whom intervention is advisable, using clinical support tools to support therapist decision making.

Since many clients in this study stated that they would have liked further input, it might be helpful for the IAPT service to review procedures around offering further sessions and when this is possible. Some aspects of the service appear to be driven by outcome scores and the same measures are used for every client. Some seemed to want support rather than aiming for change. In view of differing goals it may be more useful to better fit outcome measures to the client or to measure movement towards the client's specific goals rather than using a 'one size fits all' approach (Donnelly et al., 2011). For example, a measure which does this is the PSYCHLOPS (Psychological Outcome Profiles; Ashworth, Kordowicz & Schofield, 2012).

Further Research

Many different themes emerged as part of the final model which could warrant further investigation. For example, the theme 'A talking man learns nothing' is interesting and it may be useful to look at this in more depth, establishing when and for which clients it is most common and what type of interventions may be more useful. More generally it would be interesting to see if themes identified here are shared by others who receive psychological therapy and if they are specific to those who show negative change or if they could be applied to other clients also. This may help to validate the theory and inform clinicians further.

As some clients noted, positive change may have been something that took time to develop so it could have been useful to administer outcome measures at a follow up time, to see if negative change was still seen. Indeed, a recent trial of long-term, psychoanalytic psychotherapy found exactly that at follow up 2 years following therapy (Fonagy et al., 2015).

In future, it would also be useful to select clients who experienced negative change during therapy when external problems and social adversity are controlled for. This may help to focus more on process issues which had a negative impact rather than on circumstances external to therapy.

Conclusions

The emerging model provides a useful overview of experiences of therapy which may contribute to the process of negative change, highlighting the importance of paying attention to context and life events, alongside what clients expect from therapy. Issues around wanting further input arose frequently and therapy offered often felt too brief. It is important to note that some clients did not think there had been a negative outcome and some noted that change was not instant. Some issues raised appeared to contradict others, for example, some clients did not like the emphasis on their talking whereas others felt that the therapist advised them too much. This highlights the need to adjust interventions to fit with individual clients and their goals.

References

- Antrican, J. (2009). Why psychological therapies need a different style of regulation. The Guardian. Retrieved August 5, 2016, from <https://www.theguardian.com/society/joepublic/2009/jul/01/state-regulation-psychotherapy-counselling>
- Ashworth, M., Kordowicz, M., Schofield, S. (2012). 'PSYCHLOPS' (Psychological Outcome Profiles): An outcome measure. Integrating Science and Practice, 2, 36-39.
- Becker, H. S. (1998). Tricks of the trade: How to think about your research while doing it. Chicago: University of Chicago Press.
- Bergin, A. E. (1963). The empirical emphasis in psychotherapy: A symposium. The effects of psychotherapy: Negative results revisited. Journal of Counselling Psychology, 10, 244-250.
- Bystedt, S., Rozental, A., Andersson, G., Boettcher, J. & Carlbring, P. (2014). Clinicians' perspectives on negative effects of psychological treatments. Cognitive Behaviour Therapy, 43, 319-331.
- Callahan, J. L., Aubuchon-Endsley, N., Borja, S. E., & Swift, J. K. (2009). Pretreatment expectancies and premature termination in a training clinic environment. Training & Education in Professional Psychology, 3, 111–119.
- Clinical Outcomes (nd). Improving Access to Psychological Therapies. Retrieved on 23rd November 2015 from <http://www.iapt.nhs.uk/pbr/currency-model-description/clinical-outcomes/?keywords=reliable+change>

- Daniels, J. (2012). *Socialization to a 'new' treatment model: ways of working with people who are worried about psychological models*. In: British Association for CFS/ME (BACME) 6th Annual Conference, 2012-03-14 - 2012-03-15.
- Corbin, J., & Strauss, A. (2008). *Basics of Qualitative Research*. Sage Publications, 3rd edition.
- Donnelly, M., Scott, D., McGilloway, S., O'Neill, T., Williams, J., & Slade, M. (2011). Patient outcomes: what are the best methods for measuring recovery from mental illness and capturing feedback from patients in order to inform service improvement? A report commissioned by the Bamford Implementation Rapid Review Scheme. Retrieved on 11th April 2016 from <http://www.publichealth.hscni.net/sites/default/files/Patient%20Outcomes>
- Fago, D. P. (1980). Time-unlimited brief and longer-term psychotherapy with rural clients. *Journal of Rural Community Psychology*, 1, 16-23.
- Falkenstrom, F., Grant, J., Broberg, J. & Sandell, R. (2007). Self-analysis and post-termination improvement after psychoanalysis and long-term psychotherapy. *Journal of the American Psychoanalytic Association*, 55, 629-674.
- Fonagy, P., Rost, F., Carlyle, J. A., McPherson, S., Thomas, R., Pasco Fearon, R. M., Goldberg, D. & Taylor, D. (2015). Pragmatic randomized controlled trial of long-term psychoanalytic psychotherapy for treatment-resistant depression: The Tavistock Adult Depression Study (TADS). *World Psychiatry*, 14, 312-321.
- Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods*, 8, 59-82.

- Gyami, A., Shafraan, R., Layard, R. & Clark, D. (2013). Enhancing recovery rates: Lessons from year one of IAPT. *Behaviour Research and Therapy*, 51, 597-606.
- Hatfield, D., McCullough, L., Frantz, S. H. B. & Krieger, K. (2010). Do we Know When our Clients Get Worse? An Investigation of Therapists' Ability to Detect Negative Client Change. *Clinical Psychology and Psychotherapy*, 17, 25-32.
- Jacobson, N. S., Follette, W. C. & Revenstorf, D. (1984). Psychotherapy outcome research: methods for reporting variability and evaluating clinical significance. *Behavior Therapy*, 15, 336-352.
- Jonsson, U., Alaie, I., Parling, T., & Arnberg, F. K. (2014). Reporting of harms in randomized controlled trials of psychological interventions for mental and behavioral disorders: A review of current practice. *Contemporary Clinical Trials*, 38, 1-8.
- Kroenke, K., Spitzer, R. L., & Williams, J. B. W. (2001). The PHQ-9: Validity of a brief Depression Severity Measure. *Journal of General Internal Medicine*, 16, 606-613.
- Lambert, M. J. (2012). Helping Clinicians to use and learn from Research-based Systems: The OQ-Analyst. *Psychotherapy*, 49, 109-114.
- Lambert, M. J. (2013). Outcome in Psychotherapy: The Past and Important Advances. *Psychotherapy*, 50, 42-51.
- Lambert, M. J., Bailey, R. J., White, M., Tingey, K. M., & Stevens, E. (2015). *Clinical Support Tools Manual – Brief Version 40*. OQMeasures LLC.
- Lambert, M. J., Bergin, A. E., & Collins, J. L. (1977). Therapist induced deterioration in psychotherapy. In A. S. Gurman, & A. M. Razin. (Eds.), *Effective Psychotherapy: A Handbook of Research* (first edition, pp 452-481). Pergamon Press Inc.

- Lambert, M. J., Morton, J. J., Hatfield, D. R., Harmon, C., Hamilton, S., & Shimokawa, K. (2004). Administration and scoring manual for the OQ-45.2 (Outcome Questionnaire) (3rd ed.). Wilmington, DE: American Professional Credentialling Services.
- Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (5th ed., pp. 139-193). New York: Wiley.
- Lambert, M. J., Whipple, J. L., Bishop, M. J., Vermeersch, D. A., Gray, G. V., & Finch, A. E. (2002). Comparison of empirically derived and rationally derived methods for identifying clients at risk for treatment failure. *Clinical Psychology and Psychotherapy*, 9, 149-164.
- Lambert, M. J., Whipple, J. L., Smart, D. W., Vermeersch, D. A., Nielsen, S. L., & Hawkins, E. J. (2001). The effects of providing therapists with feedback on client progress during psychotherapy: Are outcomes enhanced? *Psychotherapy Research*, 11, 49-68.
- Lilienfeld, S. O. (2007). Psychological treatments that cause harm. *Perspectives on Psychological Science*, 2, 53-70.
- Linden, M. (2013). How to define, find and classify side effects in psychotherapy: From unwanted events to adverse treatment reactions. *Clinical Psychology & Psychotherapy*, 20, 286-296.
- Masserman, J. H., & Carmichael, H. T. (1938). Diagnosis and prognosis in psychiatry: with a follow-up study of the results of short-term general hospital therapy of psychiatric cases. *The British Journal of Psychiatry*, 84, 893-946.

- Mohr, D. C. (1995). Negative outcome in psychotherapy: A critical review. *Clinical Psychology: Science and Practice*, 2, 1-27.
- National Health Service: Choices (2015). Retrieved on 29th March 2016 from <http://www.nhs.uk/conditions/Counselling/Pages/Introduction.aspx>
- Nutt, D. J., & Sharpe, M. (2008). Uncritical positive regard? Issues in the efficacy and safety of psychotherapy. *Journal of Psychopharmacology*, 22, 3.
- Pollack, W. S., & Levant, R. F. (1998). *New psychotherapy for men*. Hoboken (NJ): John Wiley & Sons Inc.
- Probst, T., Lambert, M. J., Loew, T. H., Dahlbender, R. W., Gollner, R. & Tritt, K. (2013). Feedback on patient progress and clinical support tools for therapists: Improved outcome for patients at risk of treatment failure in psychosomatic in-patient therapy under the conditions of routine practice. *Journal of Psychosomatic Research*, 75, 255-261.
- Prochaska, J. O., & DiClemente, C. C. (1984). *The Transtheoretical Approach: Towards a Systematic Eclectic Framework*. Dow Jones Irwin, Homewood, IL, USA.
- Rolls, L., & Relf, M. (2006). Bracketing interviews: Addressing methodological challenges in qualitative interviewing in bereavement and palliative care. *Mortality*, 11, 286-305.
- Rotter, J. B. (1966). Generalized expectancies for internal versus external control of reinforcement: *Psychological Monographs: General & Applied*, 80, 1-28.
- Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development and well-being. *American Psychologist*, 55, 68-78.
- Salzer, K. (2002). Time Limited Therapy: A Necessary Evil in the Managed Care Era? *Reformulation*, Autumn, 9-11.

- Shepherd, M., Evans, C., Cobb, S., & Ghossain, D. (2012). Does Therapy make things worse? Investigating episodes of psychological therapy where clients' scores showed reliable deterioration. *Clinical Psychology Forum*, 233, 8-12.
- Sierra Hernandez, C. A., Oliffe, J. L., Joyce, A. S., Söchting, I., & Ogrodniczuk, J. S. (2014). Treatment preferences among men attending outpatient psychiatric services. *Journal of Mental Health*, 23(2), 83-87.
- Spitzer R. L., Kroenke, K., Williams, J. B., & Lowe, B. (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. *Archives of Internal Medicine*, 166, 1092-1097.
- Strupp, H. H., Hadley, S. W., & Gomes-Schwartz, B. (1977). Psychotherapy for better or worse: The problem of negative effects. Jason Aronson.
- Thoits, P. A., Kazdin, A., Heller, K. (1986). Social Support as Coping Assistance. *Journal of Consulting and Clinical Psychology*, 54, 416-423.
- Truax, C. B. (1963). Effective ingredients in psychotherapy. *Journal of Counselling Psychology*, 10, 256-263.
- Walfish, S., McAlister, B., O'Donnell, P., & Lambert, M. J. (2012). An investigation of self-assessment bias in mental health providers. *Psychological Reports*, 110, 639-644.
- Waller, G. (2009). Evidence-based treatment and therapist drift. *Behaviour research and therapy*, 47, 119-127.
- Watzlawick, P., Weakland, J., & Fisch, R. (1974). *Change: Principles of problem formation and problem resolution*. New York: Norton.

- Werbart, A., Von Below, C., Brun, J., & Gunnarsdottir, H. (2015). "Spinning one's wheels": Nonimproved patients view their psychotherapy. *Psychotherapy Research*, 25, 546-564.
- Wesson, M., & Gould, M. (2010). Can a 'return-to-work' agenda fit within the theory and practice of CBT for depression and anxiety disorders? *The Cognitive Behaviour Therapist*, 3, 27–42.
- White, M. M., Lambert, M. J., Ogles, B. M., Mclaughlin, S. B., Bailey, R. J., & Tingey, K. M. (2015). Using the Assessment for Signal Clients as a feedback tool for reducing treatment failure. *Psychotherapy Research*, 25, 724-734.

Appendix A

QUALITY CONTROL CHECKLIST

From; Critical Appraisal Skills Programme. (2013). CASP Randomised Controlled Trial Checklist and [CASP Qualitative Checklist](http://www.casp-uk.net/#!/casp-tools-checklists/c18f8). Retrieved December 10, 2015 from <http://www.casp-uk.net/#!/casp-tools-checklists/c18f8> and Effective Public Health Practice Project (EPHPP). (2009). Quality Assessment Tool for Quantitative Studies.

Quantitative studies

- **Are participants representative of target population?**
- **Study design**
 - Randomised Controlled Trial
 - Controlled Clinical trial
 - Cohort analytic
 - Case-control
 - Cohort (one group pre and post)
 - Other
- **Was the study randomised?**
- **Was the method of randomisation explained?**
- **Were there important differences between groups before the intervention?**
- **Were any confounds controlled for?**

Blinding

- **Were outcome assessors blind to treatment group?**
- **Were participants aware of the research question?**

Data Collection

- **Were data collection methods valid?**
- **Were data collection methods reliable?**
- **Was the drop-out rate reported?**
- **What was the percentage of treatment drop-outs?**

Intervention

- Was the consistency of the intervention measured?
- Were groups treated equally aside from the intervention?

Results

- How large was the treatment effect?
- Were all clinically important outcomes considered?
- Can the results be applied in your context?

Qualitative studies

- Was there a clear statement of aims?
- Was a Qualitative methodology appropriate?
- Was the research design appropriate to address the aims?
- Was the recruitment strategy appropriate to the aims?
- Was the data collected in a way that addressed the research issue?
- Has the relationship between the researcher and participants been adequately considered?
- Have ethical issues been taken into consideration?
- Was the data analysis rigorous?
- Is there a clear statement of findings?
- How valuable is the research?

Appendix B: Letter to Client

Dear ----,

You have been invited to take part in a research study because you have been seen for treatment at your local IAPT service in the past year and you indicated that it was ok to contact you about taking part in research. The study I am contacting you about aims to find out more about clients' experiences of short term therapy, and what factors might play a part in its effectiveness. The outcome of this study will hopefully inform IAPT services as to how they can improve and as such, your input would be immensely valuable. Please read the enclosed information form for more details and if you would like to take part, please indicate this in the form provided and place it in the post in the stamped, addressed envelope provided. If I do not hear back from you via post I will contact you once via telephone to check if you have received these details and would like to take part.

Thank you for your time,

Yours sincerely,

Christina Hart

Trainee Clinical Psychologist

Dear Christina,

I would like to take part in the study and I understand that taking part is voluntary and I can change my mind at any time.

My name is -----

My contact number is -----

I prefer to be contacted by post/telephone (please delete as appropriate)

I would prefer to meet at Lewisham IAPT/in my own home (please delete as appropriate)

Appendix C: Client Information form



South London and Maudsley 
NHS Foundation Trust

Salomons Clinical Psychology Programme
Department Of Applied Psychology
Broomhill Road
Tunbridge Wells
TN3 0TF

Information Sheet

A qualitative analysis of the experience of change following therapy

My name is Tina Hart. I am a trainee clinical psychologist at Canterbury Christ Church University and I am exploring people's experience of receiving psychological therapy from their local IAPT (Improving Access to Psychological Therapies) service.

You are invited to take part in this study as you attended treatment sessions at the IAPT Lewisham service in the past year and have indicated that you would be happy to be asked about participating in research.

We are interested in how you came to the service and how you found the therapy you received, whether you found it useful or not. We would like to find out about your views, whether your experience was a good or a bad one, whether you felt better, the same, or even worse after the therapy ended. This study aims to feedback your views to the service so it could be improved for future clients.

If you choose to take part in the study it will involve being interviewed for approximately one hour at Lewisham IAPT or in your home if this would be more convenient. This interview will be audio-recorded and will include questions about your experience of receiving therapy from IAPT.

If I take part, will my comments be confidential?

For the most part, yes. The only occasion where I might have to share something you say (e.g., by speaking with your GP) would be if you told me something that

suggested there was a risk of harm to yourself or another person. If this happens, I would discuss the way forward with you first. Your GP may be informed that you were taking part in the study, but no information collected about you during the course of the study would be released to him/her. The transcript of the interview with you will be anonymised so that no-one reading it will know your name. It will not be possible to identify you from any part of your interview that is included in the research write-up. The interview data will be stored securely for 10 years and then destroyed.

Are there advantages of taking part?

Some people might find it helpful to talk about their experience of therapy. What you have to say can also potentially help others who might receive input from IAPT in the future. Your experience could help to inform improvements to the service or it may help in understanding who might benefit from IAPT services and who might not.

Are there any potential disadvantages to taking part?

Hopefully there will not be disadvantages to your taking part, but it is possible that talking about the therapy you received might be upsetting in some way.

What if I do find it upsetting?

Information will be provided to you about services in your local area in case you feel that you would like to talk to someone more about the issues raised during this study.

Are you independent of the Lewisham IAPT service?

Yes, I am an independent researcher and my aim is to explore factors that affect outcomes in psychological services such as the IAPT initiative. The findings however, are hoped be useful for the service.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the NRES Committee London – Dulwich.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. If you have a concern about any aspect of this study, you can speak to the researcher who will do their best to answer your questions (see contact number below). If you remain unhappy and wish to complain formally, you can do this by contacting Dr Daniel Salter, study supervisor; or the Research Director for the Salomons Centre for Applied Psychology at Canterbury Christchurch University, Professor Paul Camic;

Dr Daniel Salter: 03330117088

Email: Daniel.salter@canterbury.ac.uk

Professor Paul Camic: 03330 117 114

Email: paul.camic@canterbury.ac.uk

Please contact me if you would like to take part or have any questions about the study.

Christina Hart

Email – c.m.hart509@canterbury.ac.uk

Phone - 07738758386

We really value your opinion and your time and effort in taking part in this study and you will receive £10 towards your travel expenses or any other costs incurred.

Thank-you.

Appendix D: Therapist information form



South London and Maudsley 
NHS Foundation Trust

Salomons Clinical Psychology Programme
Department Of Applied Psychology
Broomhill Road
Tunbridge Wells
TN3 0TF

Information Sheet

A qualitative analysis of the experience of change following therapy

My name is Tina Hart. I am a trainee clinical psychologist at Canterbury Christ Church University and I am exploring people's experience of receiving psychological therapy from their local IAPT (Improving Access to Psychological Therapies) service and therapists' experience of providing this therapy.

You are invited to take part in this study as you have recently worked with clients who appeared to be experiencing greater anxiety or depression on outcome measures following input from IAPT.

We are interested in how your client came to the service and how you found the experience of therapy with this client. We would like to find out about your views, whether your experience was a good or a bad one, whether you felt they improved or got worse towards the end of therapy. This study aims to feedback your views to the service to inform the service about what kind of people may benefit more or less from therapy, or what kind of factors impact on clients' recovery.

If you choose to take part in the study it will involve being interviewed for approximately one hour at Lewisham IAPT or in another office if this would be more convenient.

If I take part, will my comments be confidential?

The transcript of the interview with you will be anonymised so that no-one reading it will know your name. It will not be possible to identify you from any part of your interview that is included in the research write-up. The interview data will be stored securely for 10 years and then destroyed. The only occasion

where I might have to share something you say would be if you told me something that suggested there was a risk of harm to yourself or another person. If this happens, I would discuss the way forward with you first.

Are there advantages of taking part?

Some therapists might find it helpful or enlightening to talk about their experience of delivering therapy, especially if this was challenging in some way. What you have to say can also potentially help other therapists or clients who might receive input from IAPT in the future. Your experience could help to inform improvements to the service or it may help in understanding who might benefit from IAPT services and who might not.

Are there any potential disadvantages to taking part?

Hopefully there will not be disadvantages to your taking part, but it is possible that talking about negative experiences of therapy might be upsetting in some way. The researchers recognise that any therapist can end up working with clients who do not benefit from the service and therefore hope that no blame is felt by anyone being asked to participate in this study. However, we believe that a lot can be learned from such outcomes, if you would be willing to share your experience..

Are you independent of the Lewisham IAPT service?

Yes, I am an independent researcher and my aim is to explore factors that affect outcomes in psychological services such as the IAPT initiative. The findings however, are hoped to be useful for the service although, all comments from therapists will be anonymised.

Who has reviewed the study?

All research in the NHS is looked at by an independent Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the NRES Committee London – Dulwich.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. If you have a concern about any aspect of this study, you can speak to the researcher who will do their best to answer your questions (see contact number below). If you remain unhappy and wish to complain formally, you can do this by contacting Dr Daniel Salter,

the study supervisor; or the Research Director for the Salomons Centre for Applied Psychology at Canterbury Christchurch University, Professor Paul Camic;

Dr Daniel Salter: 03330117088

Email: Daniel.salter@canterbury.ac.uk

Professor Paul Camic: 03330 117 114

Email: paul.camic@canterbury.ac.uk

Please contact me if you would like to take part or have any questions about the study.

Christina Hart

Email – c.m.hart509@canterbury.ac.uk

Phone - 07738758386

We really value your opinion and your time and effort in taking part in this study and you will receive a £10 shopping voucher to cover any costs incurred.

Thank-you.

Appendix E: Client consent form



South London and Maudsley 
NHS Foundation Trust

Salomons Clinical Psychology Programme
Department Of Applied Psychology
Broomhill Road
Tunbridge Wells
TN3 0TF

CONSENT FORM

A qualitative analysis of the experience of change following therapy

Names of Researchers: Christina Hart (Trainee Clinical Psychologist), Dr Daniel Salter (Clinical Psychologist) and Dr Inga Boellinghaus (Clinical Psychologist)

Please initial box

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and I am free to withdraw at any time, without giving any reason. ☐
3. I understand I am giving my consent to be interviewed and audio-recorded. Information about me will be kept confidential. The only occasion when information may need to be shared with anybody **beyond the research team** would be if I said something that suggested there was a risk of harm to myself or another person. ☐
4. I give permission for short extracts from my interview to be used in the final report, and any subsequent journal publications and reports. These extracts will be anonymous, with all personally identifying information being removed. ☐

5. I understand that relevant anonymised data collected during the study may be looked at by individuals from Canterbury Christ Church University.
I give permission for these individuals to have access to this data.

☐

6. I agree that my GP may be informed about my participation in this study

☐

7. I agree to take part in this study

☐

_____	_____	_____
Name of Participant	Date	Signature

_____	_____	_____
Name of Researcher	Date	Signature

Appendix F: Therapist consent form



South London and Maudsley 
NHS Foundation Trust

Salomons Clinical Psychology Programme
Department Of Applied Psychology
Broomhill Road
Tunbridge Wells
TN3 0TF

CONSENT FORM

A qualitative analysis of the experience of change following therapy

Names of Researchers: Christina Hart (Trainee Clinical Psychologist), Dr Daniel Salter (Clinical Psychologist) and Dr Inga Boellinghaus (Clinical Psychologist)

Please initial box

8. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions. ☐
9. I understand that my participation is voluntary and I am free to withdraw at any time, without giving any reason. ☐
10. I understand I am giving my consent to be interviewed and audio-recorded. Information about me will be kept confidential. The only occasion when information may need to be shared with anybody **beyond the research team** would be if I said something that suggested there was a risk of harm to myself or another person. ☐
11. I give permission for short extracts from my interview to be used in the final report, and any subsequent journal publications and reports. These extracts will be anonymous, with all personally identifying information being removed. ☐
12. I understand that relevant anonymised data collected during the study may be looked at by consultants on research conduct from Canterbury Christ Church University. I give permission for these individuals to have access to these data. ☐

13. I agree to take part in this study

☐

_____	_____	_____
Name of Participant	Date	Signature

_____	_____	_____
Name of Researcher	Date	Signature

Appendix G: Letter to GP

South London and Maudsley



NHS Foundation Trust



Canterbury
Christ Church
University

A qualitative analysis of the experience of change following therapy

Dear Dr ----,

Your patient ----- has been invited to take part in the above research study and has agreed to participate. They have also agreed for their GP to be notified about their taking part. They were invited to take part because they had been seen for treatment at their local IAPT service in the past year and indicated that they were happy to be contacted about taking part in research.

The study they are participating in aims to find out more about their experience of short term therapy, and what factors might play a part in its effectiveness. The outcome of this study will potentially inform IAPT services as to how they can improve. Please read the enclosed information form for more details.

Thank you for your time,

Yours sincerely,

Christina Hart

Trainee Clinical Psychologist

Appendix H: Interview schedules – Therapist and client

Interview schedule - Therapists

Can you tell me what led * to seek help from the IAPT service?**

(prompts – Do you remember how were they referred? Do you know what led to that decision? Were there any significant events that you know of that impacted on ****? What were the main difficulties that this client wanted help with?)

Can you tell me a bit about the experience of therapy?

(prompts – How did you find the sessions? Would you say it was a good or difficult experience overall? How did you feel *** made use of the therapy? Did you encounter any challenges during treatment and how did you cope with these? Looking back on the experience, is there anything you would have done differently (intervention, treatment, length)? What did they like or dislike about it? Do you think the client was happy with the type of treatment or would they have preferred a different type of therapy?)

How did you experience your relationship with this client?

(prompts – How did you get on with them? Do you feel like you understood the issues that had led them to be referred? Do you think the therapy went well? If yes/no, please could you explain why you think this. Is there anything that you would have liked to have done differently in terms of relating to the client?)

What was the outcome of treatment?

(prompts – Did you notice any changes in this client during or after therapy? What changes did you notice? Were they good changes or bad ones? What do you think contributed to the changes? How did you feel about these changes? Do you think the treatment helped with the client with their difficulties? If not, did they stay the same or get worse? How did the treatment end? If their problems got worse what do you think made them worse? Do you think the treatment they received made them more aware of your difficulties?

Deterioration

Has this experience changed your practice? What did it feel like to know some of your clients appeared to deteriorate? What was the emotional impact? What do you think the

purpose is of investigating negative change or deterioration? What are the potential gains, losses or negative consequences?

Interview schedule: Clients

Can you tell me what events led to you seeking help from the IAPT service?

(prompts – who referred you? Was it your GP or did you self refer? What led to that decision? Were there any significant events that caused you to be referred/refer yourself? How were you feeling at the time? What were the main difficulties you wanted to get help with?)

How do you feel about the experience of therapy overall?

(prompts –? What was the experience like? How did you experience going to the sessions? How did the therapy sessions make you feel? Were there any challenges you encountered during treatment? If so, how did you cope with these? What do you think about the type of treatment you received? What did you like or dislike about it? Would you have preferred a different type of therapy?)

How did you experience the relationship with your IAPT therapist?

(prompts – How did you get on with your therapist? Did he/she seem to understand your problems and feelings? Did you feel listened to? Was there anything you liked about your therapist? If so, what did you like about them? Is there anything that you would have liked to be different about your therapist? Do you think you would have preferred a different therapist? If so, what makes you say this?)

How did the treatment impact on your life?

(prompts – Did you notice any changes in yourself or your life during or after therapy? Were they good changes or bad ones? How did you feel about these changes? If there was change, how long has the change lasted? Is there anything different for you now? Do you think the treatment helped with the difficulties you had before therapy? If not, did they stay the same or get worse? If your problems got worse what do you think made them worse? Do you think the treatment had an impact on how aware you are of your difficulties?)

Appendix I: Transcript from Bracketing interview

L: Tell me a bit about your research so far

T: OK, so, it's going to be looking at people who've had therapy from an IAPT service, who seem to have come out worse than when they started on the outcome measures, there's a reliable deterioration, score deterioration basically on the outcome measures. It's quite a small percentage, but I think the trouble is, in the research, there tends to be emphasis on whose done well or the percentage of people who've come out better or not, whereas actually, it's looking at those people who seem to have deteriorated in their symptoms, or their symptoms have got worse – what's happened there? What's that experience like?

L: That does actually sound really, really interesting

T: Well hopefully yeah, it should be really interesting – so I'm trying to interview both clients and therapists and create a grounded theory about the experience of negative change.

L: So what were some of your initial interests, as a researcher, in this topic?

T: I don't know, I suppose, I like, I'm quite interested in when things don't go as they're intended to go.... And I wouldn't say I'm necessarily critical of IAPT, because I've never worked in that service and I've never had input from it, although obviously I've got my own opinions about what maybe good and what might be bad about it.

L: Tell me a bit more about that, what are your own opinions about what might be good and what might be bad?

T: About IAPT? My initial opinion when I heard about IAPT was that, this is really good, because it came from a background of people being given medication, basically, as the first stop and the kind of only approach, when they go to the GP and say, ya know, this is how I'm feeling – you get tablets. And so my initial impressions of it were good. It was a good thing that people were getting access to psychological therapies. But the stepped care model, if you come and your symptoms are not that severe, potentially you get self-help and you get sent out manuals and stuff to fill in yourself and you get to speak to people on the phone, I'm not too sure about that. There's lots of reasons I think that might not be ideal and I wonder if that puts people off of the service. I suppose that doesn't really relate too much to this study that I'm doing because these are people who've got to the stage where they're in a room with somebody and they've got to come and speak to somebody, which is a stage that I would think is a good thing. But it seems like it hasn't helped, I guess, partly I'm not sure whether that's what I'm gonna find, that the scores on outcome measures represent an actual deterioration or whether they just represent something that comes out on an outcome measure. Because there's research that looks at outcome measures and what they tell you, and whether they pick up on change or something else, and whether deterioration means that you have more insight, whether you've come in thinking, you probably wouldn't come in thinking 'I'm fine' but not necessarily knowing how to name what you were feeling and you go out thinking 'actually, these are some of the symptoms that I have had'. So then, perhaps you come out as 'deteriorated' for those reasons.

L: What are your thoughts about, just in terms of gaining access, about services and issues around power and, in your position, having a degree, and working with the people that you're working with and in terms of kind of, access to these people and these services, have you thought much about that?

T: I suppose what I have thought about is, that these are people who may have come out feeling worse when they've seen a therapist who could be like me. I mean I work one to one, giving therapy, so I'm asking someone to come and speak to someone similar. I am saying I don't work within IAPT, I'm at university, but I could potentially be the person offering therapy and I want them to talk to me about – what your experiences were like. I mean, I'm not gonna go to people and say look, you know, it looks like you've experienced negative change because that's potentially damaging for someone to hear, so I'm gonna have to be careful about how I phrase what I want to speak about, which is a bit tricky, I think. I had trouble getting the proposal approved because if you think, ooh why are they gonna wanna come and speak to you, which is a fair point. That's as far as I've thought really, in terms of being in a position of power.

L: What about other factors like race, gender, socioeconomic status and I guess the political context and those sorts of demographics and how that might interfere with your research or just interrupt your research?

T: I guess, when we had the data, that said, this percentage of people have done worse, one of the angles we could of taken was to just try and look at all the demographic factors that IAPT records and say, ya know, is it something to do with race, or class, or things like that and that's not really the angle that I've gone down. I'm not sure if I've read anything about stuff like that and so I would say it's not something I've given a great deal of thought to, no.

L: Are you able to articulate your own personal value system and acknowledge areas where you might be (suggestive?) In your setting?

What might have orientated your motivation in your study? What might you be looking out for?

T: That's quite a difficult one, I'm not sure about my value system necessarily I'm kind of confused by that term because it sounds so broad, I don't really know where to start, but I guess I'm thinking about the therapeutic relationship and maybe thinking about what might be my own difficulties in that situation, so I have been in situations where I've been sent to get therapeutic input, it wasn't from IAPT and it was a bit different, but I didn't want to talk to the person and I've got my own preconceptions about the difficulties people might have, I suppose, in talking to someone, or wanting to talk to someone, or looking at someone that seems so different to them and thinking, 'what's the point in talking to you?' that's the only thing I can think about that seems relevant in relation to that question.

L: Can you describe possible areas of potential role conflict? Particular types of people or situations in which you might feel anxious or annoyed or at ease?

T: It could be that going back to the fact that I could easily be working as someone's therapist, it might be difficult for me to speak to someone whose very critical of approaches that maybe I've used myself. So maybe if I think, I dunno, let me think how to put it, I was gonna say if they haven't understood the process or it hasn't worked, but it seems like there would definitely be some biases if the person talks about something and it sounds like something I would have done, that really wasn't useful, or if they describe something about the therapist which I identify with and that's one of the things that they talk about that wasn't helpful, that could potentially be upsetting for me and make me feel that I'm not very good at what I do or I could be taking it on board or I could potentially get defensive about it. If it's something that's difficult for me to hear then I may explore it less.

L: And if the publication of your findings cause problems with a particular group of people, how could this maybe influence the approach that you use?

T: I thought about that in relation to IAPT, because obviously it has it's problems, which I mentioned before. But I did think IAPT was a step in the right direction and a good thing and I realise that, particularly at this time, IAPT are really trying to sell what they do and get commissioning so that the services can improve. And I'm quite aware that I don't really want my study to come out and say that they're not very good in some way and someone to read that and take it as like, ya know, 'let's scrap this cos it's not really working' that's not what I want.

L: Second part of interview!

So we were thinking about, just getting it published and what problems it might cause...

T: Yeah, so I didn't want it to be damaging to IAPT particularly. I hope it comes up with recommendations, you know, that there's things that might need changing, but I don't want it to come with some really negative view of what they offer and I suppose, if I speak to therapists as well, getting their point of view maybe helpful to avoid that, but because it's a grounded theory obviously I'll work with what people come up with. If they start going down that road of how negative things were then that's, that will be my findings. So I would be concerned about that.

L: So are you able to acknowledge or identify some of the feelings that go along with that?

T: (big pause) I'm not sure! It's just apprehension really.. so you can tell that you wouldn't want people to go too much down a very critical, negative line, but you're giving them the space to say whatever. So the feelings are worried and apprehensive about that.

L: Can you identify the gatekeeper's interests and to what extent they are disposed favourably toward the project?

T: Who is the gatekeeper?!

L: I'm thinking it's the person who gives you access to participants

T: So that's the IAPT service, so my supervisor is from IAPT and works in an IAPT service so the question was identify..?

L: Their interests, but you kinda talked about that, so how they might be disposed favourably towards the project

T: I think that it's quite tricky in terms of what potentially I'm looking at and what I might find. So you know, when I was writing the proposal I had to rephrase things and trying not to make it look like I was saying that IAPT were doing something wrong and I wanted to find out what it was, because if you're working within that service, you probably do have some allegiance to that and you want it to come across positively or maybe even you have some concerns about the service and you're hoping that it's gonna identify those concerns

L: (Note about thinking about intensity of feelings and neutrality.)

So I don't know whether you feel it has tinted your neutrality – having anxious feelings or...

T: Yeah I guess if you have any apprehension about the way things are gonna come out, then there's a chance that you are going to try and, consciously or unconsciously control what people say, and counteract that – try and find opposing statements, yeah.

L: Can you think of any examples where you might have sought out situations to try and help you feel more positively about this?

T: About the service, or?

L: About your project, so, you might avoid situations that would trigger negative feelings from people or vice versa. Or you might seek out situations that will help you feel a bit more positive about your research.

T: I suppose, I've probably mentioned it to people who've had therapy or to other people who might be critical of IAPT as like, this is a way that you can find out about these people, and this is a way that we can find out about certain experiences that people might have had, and that's probably what led to me starting to feel a bit worried because I was thinking, I'm not doing this study to say 'ooh look at this, this is crap' so that concerned me a little bit. But obviously, you can find yourself promoting what you're doing, when you tell people about it, like why is this interesting, it's like well, it gives, potentially it gives a voice to people who may not have had a good experience and who want to talk about it, and then the services can hopefully improve as a consequence of that.

L: So something about mixed feelings

T: Yeah it is, because I think that there are some people who do seem to be negatively biased towards IAPT and who don't like it and I appreciate that there are definitely things not to like, but that's not what I'm looking at.

L: In terms of both you worrying, your sort of anxiousness about these others and stakeholders and their reaction and also about your feelings about your participants being given a voice. Can you identify the origin of those feelings within you?

T: All I can think is, that they're, you said I had mixed feelings, and it's because there's like 2 opposing views here. You said about the gatekeepers or my supervisors who work within IAPT, initially I didn't feel entirely comfortably with being supervised by people who just worked within IAPT, because I thought, well these people are very motivated that the service comes out looking good and that I don't say anything controversial, but what if something controversial does come up? Am I supposed to try and sugar coat it and rephrase it and package it? That's not what I want to do, so then that probably led to me, ya know, selling it to people outside of that service and saying, this is really important and then getting really positive feedback about that, about how great that would be, because obviously there's so many people who've had a bad experience and that's made me wary as well, so it's difficult, I mean I must have had some similar feelings about these people who've had a bad experience, but then when I get feedback on that, it sometimes worries me how much people might be wanting to find something wrong with that service.

L: I think what I'm trying to get at here, is being aware of in your own past experience, that this dynamic that you're worried about that might be created with your project, has that reflected any personal experience that you've had in your past with those sorts of power dynamics?

T: Yeah I think it's going back to what I said before about being the person in the room with the therapist who thinks 'who are you? You won't be able to understand' I mean in fairness, I was a teenager at the time, so I was sitting in the room thinking you don't understand me, I'm not going to talk to you basically and it didn't work, but yeah I probably initially came from that position, somebody who is like, yeah I've had that experience of thinking this is not gonna work. I mean I've had later experiences that were better, but, because I've seen a therapist more recently, not that recently but fairly recently and that was more good and bad, I can recognise that I took some good

things from it, but I also had problems with that as well, where it was like, 'I wanted to talk about this, and you didn't talk about that with me' you know, just wanted to hear what I was bringing to the room every time I came, and I was thinking well this is not what I'm here for, so I guess, yeah, so maybe that's one reason that I did chose this project, maybe I saw it and I was like yeah, maybe I had that experience. I don't know because I didn't fill in outcome measures but maybe I felt a bit like that at the time, like what was the point of this. I think even that though, I have to say, that I changed my view and that, even if you leave therapy and think, what did that do, that was not helpful, that was not what I wanted to do, she just kept going down these other routes that were not what I wanted, with time, you do kinda think, oh actually, this bit was useful, and maybe she was trying to do this or maybe that did help me, although at the time, I didn't feel like that, so that's maybe something about what I was saying about have they deteriorated or not? Like do they look like that initially and then, because I definitely read things where it's like, the therapeutic process continues outside of therapy, so the therapist puts so much importance on themselves as like, 'I have to help this person and that's how they're gonna get better' but actually you give people skills, that they then go out and use and then they grow more themselves, so if you were to check them long term there might be an improvement that you didn't notice before.

L: So there's a real journey that you've been on, with the understanding that the people that you're interviewing are also somewhere on their own journey, a similar journey, that has some parallels to your journey either currently, past or in the future, and that experience and that journey, how do you think might or might not alter your own thinking on the project with your participants?

T: I think naturally when you have a conversation with somebody, you try to establish the things you have in common and that's maybe what helps conversations flow. So if I'm doing a semi-structured interview, I've not got many questions and I'm gonna go wherever it takes us, there is a danger of me, hearing the things that I recognise that I've experienced and going 'oh yeah' and taking it down that line, rather than the thing I hear which doesn't ring true for me. So I think, okay I don't know much about that so there's definitely a danger of you guiding the conversation down the lines that you're familiar with, so that's definitely something to be aware of.

Reminder to revisit this thinking throughout analysis!

Notes while transcribing;

Avoided topic of race and gender even though it's probably likely that I will feel more comfortable talking to someone I identify with in this respect. Also class, if someone seems more upper class or more educated I will potentially feel more anxious while interviewing them.

Didn't really discuss preconceptions about what I will find – number of sessions IAPT provide, time limited work, too structured/manualised, life events playing a major factor.

Appendix J: Abridged Research Diary

4/07/2014: Regarding my chosen project: I'm quite interested in when things don't go as they're intended. I wouldn't say I'm necessarily critical of IAPT; I've never worked in that service and I've never had input from it. I've got my own opinions about what may be good and what might be bad about it. I wonder if a service that just aims to work with depression or anxiety or more 'primary care' issues may be too narrow? I wonder if the stepped care approach puts people off if they get something at first which doesn't seem to be enough? The use of self-help and telephone sessions also interests me, although I don't think I will be looking at these interventions.

18/8/2014: Rewriting my research proposal following the first submission. The feedback was around whether I would be able to get enough clients who wanted to take part, particularly bearing in mind that they might have had a bad experience with the service. It seemed that my supervisors thought I should just speak to therapists as they would be easier to recruit. I didn't want to do this as I felt that I would get a more realistic impression about how clients actually experienced therapy if I spoke to clients. Also I hadn't seen any studies which had done this and I thought it was really important. In the end I chose a grounded theory methodology because there are currently no theories of negative change and it would allow me to be flexible in who I recruited and source more than one type of information.

19/9/2014: My second proposal is approved by Salomons.

21/9/2014: Reading about grounded theory and thinking about my epistemological approach. It's quite difficult to get your head around what the differences are. I'm still reading papers and trying to decide.

5/10/2014: I have started the process of applying for NHS ethics. I have done this once before but it's still very complicated and time consuming. I find it difficult to be very specific while sticking to the GT approach too, when ethics applications demand that you define exactly what you will do and say, it's difficult to see where there will be room for flexibility and reflexivity. We have also decided as a team that clients will not be informed of the exact reasons why they are being contacted (negative change). This is so that they are not upset at hearing about something that they may not already know and might make them feel bad about themselves. I find it difficult to decide what I should actually tell them though and feels difficult to be deceiving them.

18/11/2014: A friend of mine recommended Fast-R, a service based at Kings College where you can get service user feedback on your project design. They sent feedback which was useful to have. It seemed they had reviewed it without much knowledge of the GT methodology. For example, they have spoken about how it is too big a task to construct a theory as part of an MRP. Although they may have a point perhaps it is not clear that this would be a postulated theory to inform further research. I have responded addressing the points they raised.

10/12/2014: I have received a letter from NHS ethics with a date for my project to be reviewed.

15/12/2014: I'm not sure whether if I'm going to find that the scores on outcome measures represent an actual deterioration or whether they just represent something that comes out on an outcome measure. Because there's research that looks at outcome measures and what they tell you, and whether they pick up on change or something else, and whether deterioration means that you have more insight, whether you've come in thinking, you probably wouldn't come in thinking 'I'm fine' but not necessarily knowing how to name what you were feeling and you go out thinking

‘actually, these are some of the symptoms that I have had’. So then, perhaps you come out as ‘deteriorated’ for those reasons.

14/1/2015: Attended the ethics review of my project. I was quite nervous but think it went well, although it is difficult to explain the GT methodology at times, particularly as it is new to me. There was a GP in attendance who thought it would be important for clients GPs to be informed that clients had taken part in the research project and so an additional letter was requested. There was also concern around whether participants might become upset, but the fact that I do therapy work with clients myself seemed to allay some concerns.

3/3/2015: I’m starting to think about section A, the literature review. It seems that there is little research into negative change in terms of studies which aim to look for correlates although there is a few papers which discuss this.

20/6/2015: I get my first letter response from a participant saying that she would like to take part. Very pleased that I have managed to recruit via post. I have contacted her and arranged to meet at the IAPT clinic.

2/7/2015 - Participant 1: This was a middle aged, white British woman who seemed well-educated and had a lot to say. Her experience of therapy seemed like it had been mostly positive. The main negative outcome for her seemed to be when therapy stopped and she didn’t feel ready. This first interview went well and made me think more about whether the people I would recruit had actually experienced negative change.

9/7/2015 - Participant 2: This was an older, white man who spoke very quietly and was difficult to understand at times. In his speech he came across like someone who drinks/has drunk a lot of alcohol because it was quite unclear. However, I have no idea if this was the case. His experience of therapy was not unanimously positive. He openly described himself as someone who does not like talking, which may have impacted on the benefits he could derive from talking therapy. Because I found him difficult to understand at times, this did make me wonder whether the therapist had a similar experience.

20/7/2015 - Participant 3: This was a young, female, Muslim therapist who had a lot to say and went over the hour allocated for the interview. This may be unfair but I couldn’t help but wonder how much she spoke in therapy sessions as she talked a lot and was difficult to interrupt. I interviewed her about one client in particular and she described the therapeutic process as mostly positive but with some significant challenges. I telephoned this client to ask if he would take part in the study but he told me he hadn’t found the therapy useful, but did not want to talk about the reasons why, and did not want to participate in the study. I’m wondering if this was an example of a therapist have a falsely positive impression of their own work.

31/7/2015 - Participant 4: This person struck me as still needing help and I helped him to arrange an appointment with his GP to refer back to IAPT. He was a middle aged man, muslim I think. I can’t help thinking whilst I transcribe his interview, and whilst thinking about the previous therapist interview too, what massive problems psychologists are expected to help with – the injustice of life! And people come and they say, this is what happened to me and nothing can change it, they can’t accept it and can you help them to? Because it isn’t fair and it isn’t just. I also wonder whether the power of being listened to and acknowledged works better for women – these last 2 interviews are examples of men who have been listened to, but ultimately there are no solutions – is that what they want more of? Are men more likely to do worse? Following this I checked my sample of clients who deteriorated to see if men were over-represented but there was not clear evidence of this.

10/8/2015: Both before and during the process of my MRP I have often had conversations with other trainees about my project. I was aware from the beginning of the project that some have a very negative view of IAPT and talked about this during the bracketing interview. Recent conversations with other trainees have gone down the same lines and people have talked about, 'some psychologists needing to stand up' and talk about the problems with IAPT, for example, the fact that it is a business model and fits into this society in terms of the emphasis on employment and productivity, ie, it is cost effective because it will get people back into work and the government will no longer have to pay benefits. Another trainee who previously worked as a PWP within IAPT said that the approach maybe works for about 50% of people and that mostly people don't get to see qualified psychologists or therapists, but rather, PWPs who have completed a year's training. They criticised the constant filling out of forms and ticking boxes and reluctantly acknowledged that it does help some people. I often don't find these criticisms comfortable as I initially felt IAPT to be a positive step in the right direction and feel disappointed if this isn't the case. Perhaps the problem is with the 'one fits all' approach, but it was my understanding that IAPT would be branching out and providing other types of therapies. Other trainees also described how counselling services were available previous to IAPT and that a better model would be to station psychologists in GP surgeries, although that would probably be considered as too expensive. I believe it's worth noting these discussions as they will clearly colour my opinions and thoughts going forward.

6/8/2015 – Participant 6: This was an Asian women who worked as a nurse but was currently on maternity leave and so had a young child. I went to her home because of this. She was very talkative and a bit critical about the therapy she had. She talked a lot about feeling criticised by the therapist or being told what to do. I did note in the instances that she described that she seemed to be rather sensitive in terms of whether some things were taken as criticisms though. And I could not help wondering what the therapist's perspective might be, but this therapist had not responded to my emails.

24/8/2015 - Participant 7: This was an older, Caribbean woman whom I interviewed at her home. There was an older man sitting in the same room as us whom I assumed was her husband. She told me that she was fine to do the interview whilst he was sitting in the room (he was watching breakfast TV), but I couldn't help thinking that his presence may inhibit or impact on what she chose to talk about. She told me from the start that she didn't know how helpful she could be as she couldn't remember much about the sessions she had, and she had problems with her memory, however, she agreed that we could give it go and see what she could remember.

She had received counselling sessions but couldn't remember the name of the counsellor although she knew it was a woman. She told me that she had had counselling once before and it had been helpful, but this time it was not really, but she wasn't sure why. There were lots of things she said she couldn't remember and that she often had trouble thinking of things she wanted to say, such that she may remember things she could have told me after I'd left. I couldn't help but wonder whether these memory problems may have also impacted on the usefulness of the counselling she received.

She seemed to be struggling to answer some of the questions I asked and I wasn't sure if it was because; I was asking her to think about difficult things, she couldn't remember the answer and was frustrated or she was just annoyed about the question. She didn't seem to like talking much and was very softly spoken. I wondered if this had also impacted on the benefits she could gain from talking therapies.

16/10/2015 - Participant 8 : This was a younger client (say mid to late thirties) with a newborn baby. She was somewhat abrupt when I telephoned her before the appointment, demanding why I hadn't called her mobile since she was breastfeeding. I explained that her landline number was what I had and had used previously (she had never asked me to use her mobile). She paid for my parking and refused to take any money for this, she also refused payment for participating. She talked at length and was quite well-spoken. She was not easy to interrupt whilst talking and she became upset at one point. I must admit that her description of the nature of her issues and how she is 'known' to her GP made me wonder whether she would fit the description of a complex condition such as BPD. She also described herself as a perfectionist who could be very demanding.

29/10/2015 - Participant 9: This was a female clinical psychologist. One thing she said during the interview was that she wondered if the client would have been better off being seen by a 'CBT therapist'. She explained this in terms of psychologists potentially getting distracted by a myriad of different avenues. This phenomenon is notable as something that also appeared to happen for the counselling psychologist, participant 3, although she didn't mention it being a problem. Participant 5 (a trainee psychologist) also noted that it was difficult to stick to a CBT protocol with her client and there seemed to be a lot of 'wanting to offload'. This is a theme in several of the interviews.

17/2/2016: First meeting with Sue Holttum and my lead supervisor about the emerging model (according to the first 5 interviews). I've been finding it really difficult to move from themes to an actual theory. Sue was really helpful with her feedback, she encouraged me to draw diagrams for each participant so that I could link themes – did one thing seem to lead into another? Are there hypotheses regarding potential causes of negative outcomes? My current code system really showed how I was much more used to quantitative designs, particularly in my hesitance to make any leaps in logic and go beyond or infer things from the data rather than just stating what the data showed and trying to categorise responses.

22/2/2016 - Participant 11: This was a male counsellor, he was a white Scottish man who appeared middle aged. He was friendly although quite serious and intense. The first question he had was what had led me to him and why I had contacted him. I felt a little uncomfortable and I also felt like he was rather defensive, I was not sure if he was offended that I had contacted him or he had taken it badly, but I remembered that another male counsellor had seemed defensive in his email correspondence. The counsellor often gave one word responses and fixed me with a gaze that was fairly stern. I felt awkward pressing him for further information, particularly when I felt I had to clearly state that the client concerned had appeared worse according to outcome measures. I sometimes felt I was giving him 'get out clauses' to explain what had happened – probably because I felt awkward. After I had stopped recording the counsellor told me that he didn't want to say on tape, but he was now seeing the client privately, since she had contacted him regarding further sessions. I wondered why he didn't like to mention this on tape and he was saying that he felt 'very defensive' of his clients, we thought about whether it might be confidentiality that he was worried about but this was not clear.

If I had known the counsellor was still in therapy with the client, I probably would not have conducted this interview.

I feel like I'm being a bit suspicious of this counsellor and I'm not sure why, but I just remembered that when I first met him he said he had been just about to look on the notes regarding the client to refresh his memory but the system was down so he hadn't been able to. I think this now sounds strange in light of the fact that he reported after the interview, that he is still seeing the client privately.

1/3/2016 – Now I have finished interviewing I am trying to make sense of all the information. Using MAX-QDA to code. There is so much information though. It's really difficult to hold everything in mind.

23/3/2016 – Second meeting with Sue Holttum to look over participant diagrams and my initial model. The diagrams have been really helpful to generate hypotheses about what may have 'caused' negative change for each participant. It's still difficult to incorporate into one model though, since most participants seem to have had a very different experience.

1/4/2016 – I've noticed in reviewing my write-up that I have not talked about the therapist client pair who I interviewed. Their different perspectives are interesting, particularly in light of some research I have read, for example the paper by Glen Waller which my IAPT supervisor recommended that I read. This talks about therapist drift, away from the CBT approach. One situation talked about is crisis and how this does not mean you should drift from the model, but I think that's exactly what happened with this pair. He experienced a crisis and she went in to 'fire-fighting' mode and he was left wondering about that first insight and how it did not come again.

15/4/2016 – Final meeting with Sue Holttum. We looked at the final model and I told her about concerns from my supervisors that there were not enough postulated links or evidence of one thing leading into another. She suggested having a timeline or at least more of a sense of participants 'moving through' the model. We also discussed some of the individual themes and whether they belonged in each part of the model. She advised postulating links and then looking back through the interview data for evidence which would confirm or disconfirm these.

23/4/2016 – A bit late in the day but I am re-doing my grounded theory model and trying to incorporate different advice from supervisors – I have now had feedback from Sue Holttum, my 2 current supervisors and 2 previous supervisors, including Melanie Shepherd who was the supervisor who originally proposed this project idea. It now looks slightly different so I need to go back over the data, and change my results and discussion section. So much to do and so little time!

Appendix K: Approval letters from ethics and Research and Development
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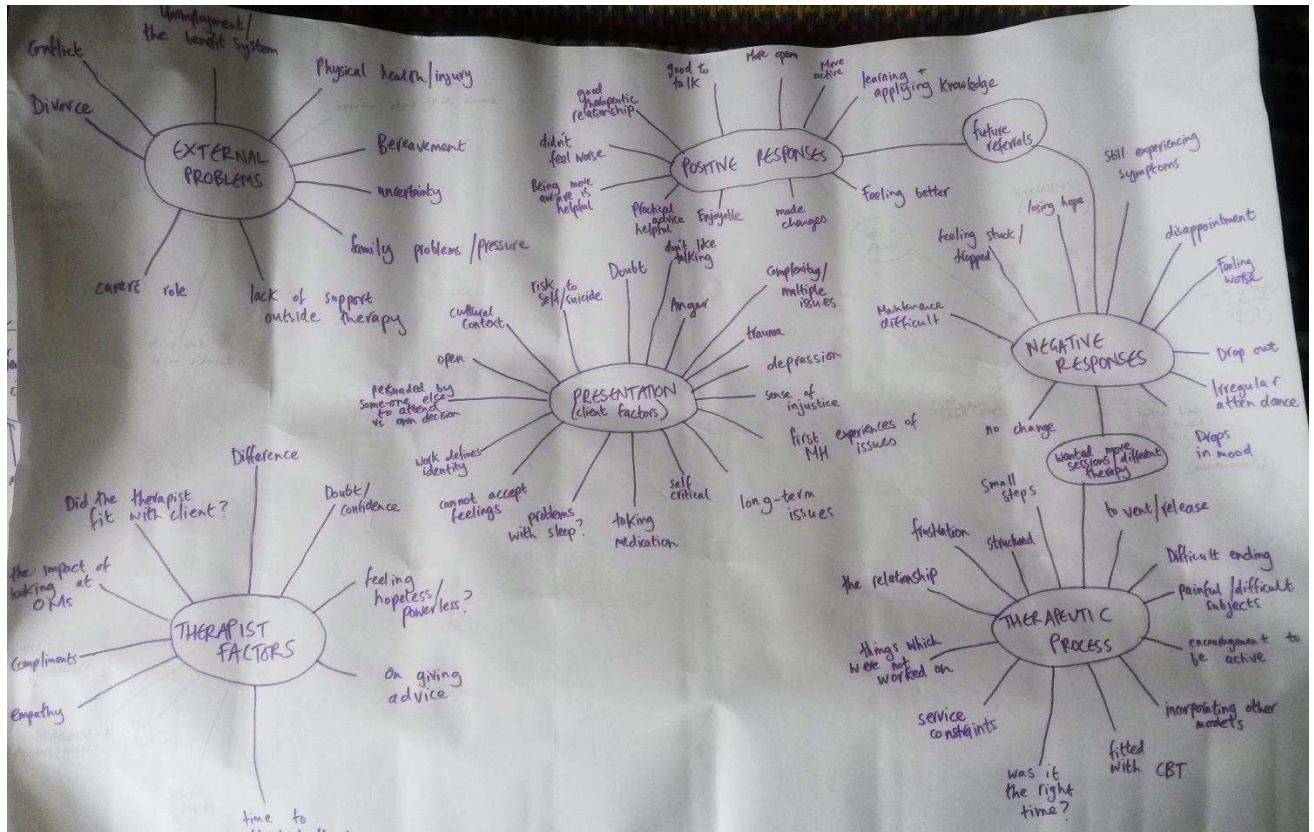
Appendix L: Coded Transcript
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Appendix M: Inter-rater codings

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Appendix N: Progression of theme development

Initial spider diagram



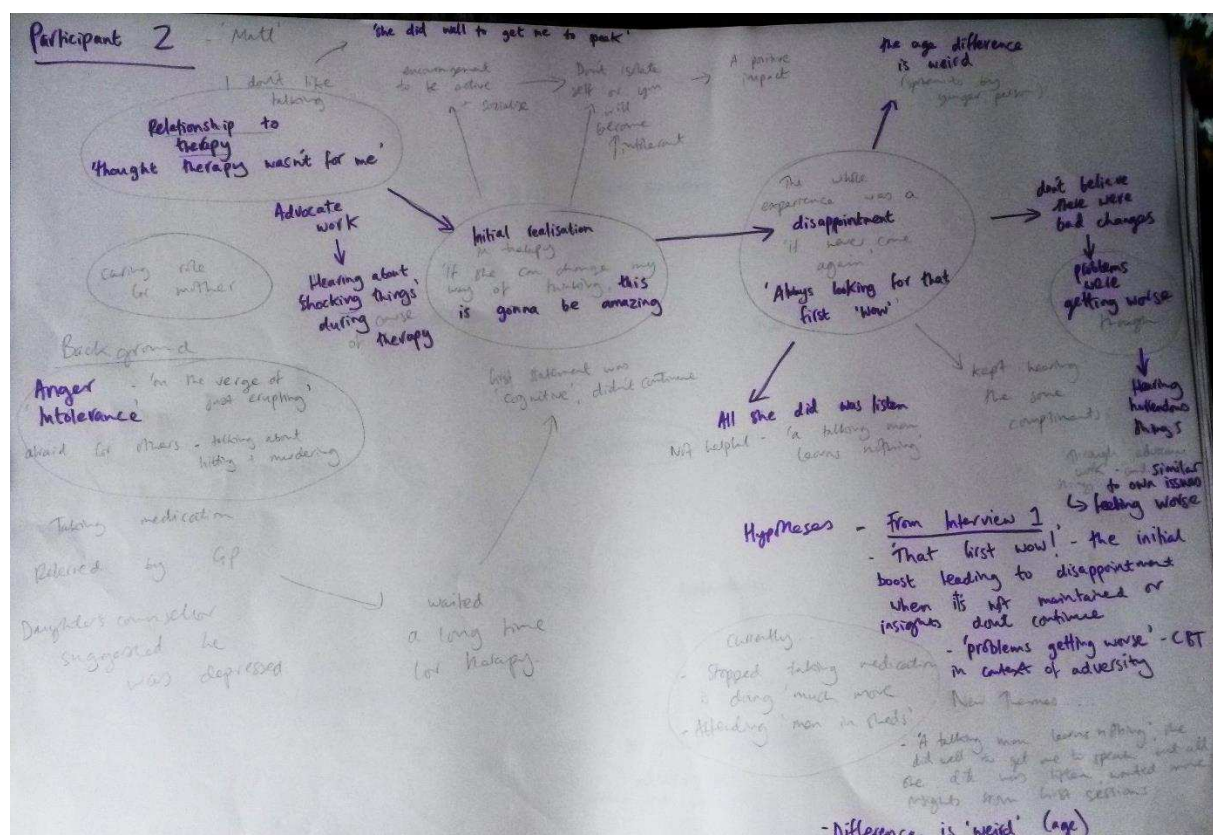
Codes from initial spider diagram (following first 5 interviews)

External problems	Conflict
	Divorce
	Unemployment/the benefit system
	Physical health/Injury
	Bereavement
	Uncertainty
	Family problems/pressure
	Lack of support outside therapy
	Carer's role
Therapist factors	Difference
	Doubt/confidence
	Feeling hopeless/powerless
	Did the therapist fit with client?
	On giving advice
	Time to think/reflect
	Empathy
	Compliments

	The impact of looking at outcome measures
Presentation (client factors)	Risk to self/suicide
	Doubt
	Anger/sense of injustice
	Complexity/multiple issues
	Trauma
	Depression
	First experience of mental health issues
	Long-term issues
	Self-critical
	Cultural context
	Persuaded by others to attend therapy
	Open
	Work defines identity
	Cannot accept feelings
	Problems with sleep
Positive responses	It's good to talk
	More open
	More active
	Learning and applying knowledge
	Feeling better
	Made changes
	Enjoyable
	Practical advice is helpful
	Being more aware is helpful
	Didn't feel worse
Negative responses	Good therapeutic relationship
	Losing hope
	Still experiencing symptoms
	Disappointment
	Feeling worse
	Drop out
	Irregular attendance
	Drops in mood
	No change
	Feeling stuck/trapped
	Maintenance difficult
	Wanted more sessions/different therapy
Therapeutic process	To vent/release
	Difficult ending
	Painful/difficult subjects
	Encouragement to be active
	Incorporating other models
	Fitted with CBT
	Was it the right time?

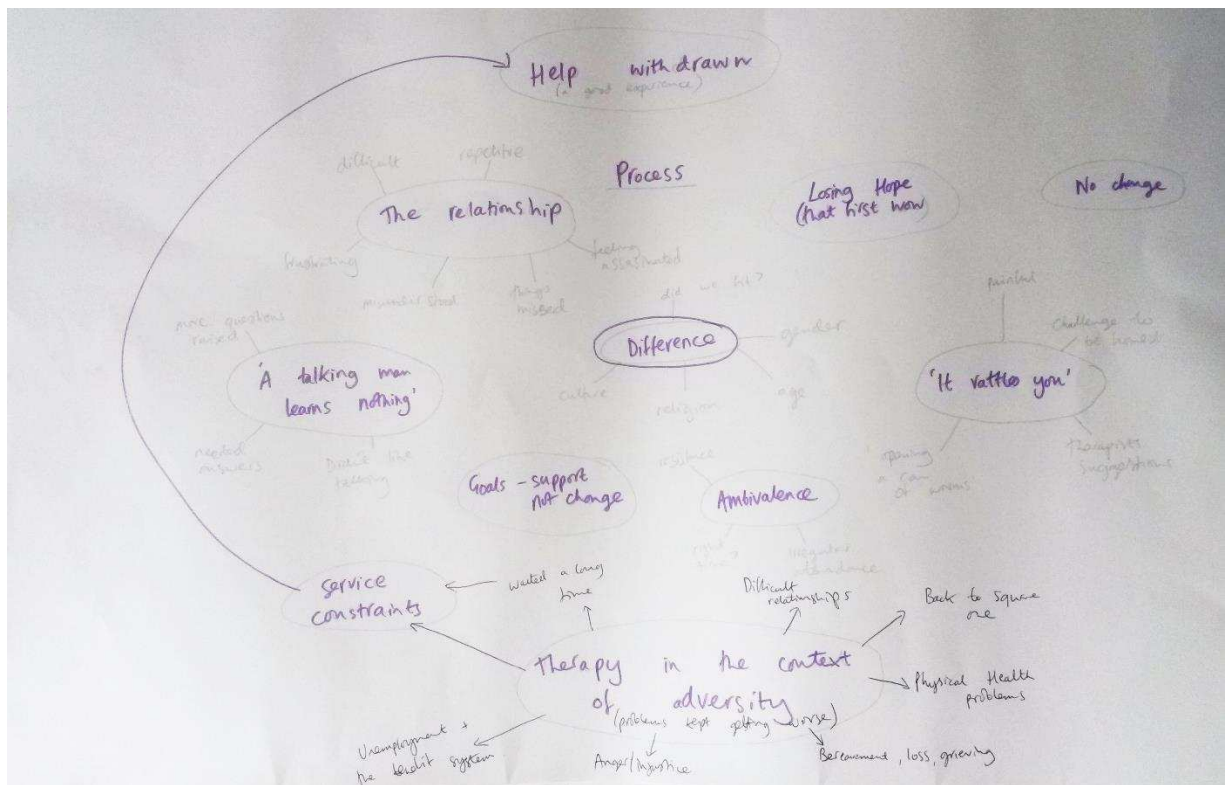
	Service constraints
	Things which were not worked on
	The relationship
	Frustration
	Structured
	Small steps
Future referrals	Linked to both positive and negative outcomes

Examples of individual client diagrams drawn to map out relationships between themes

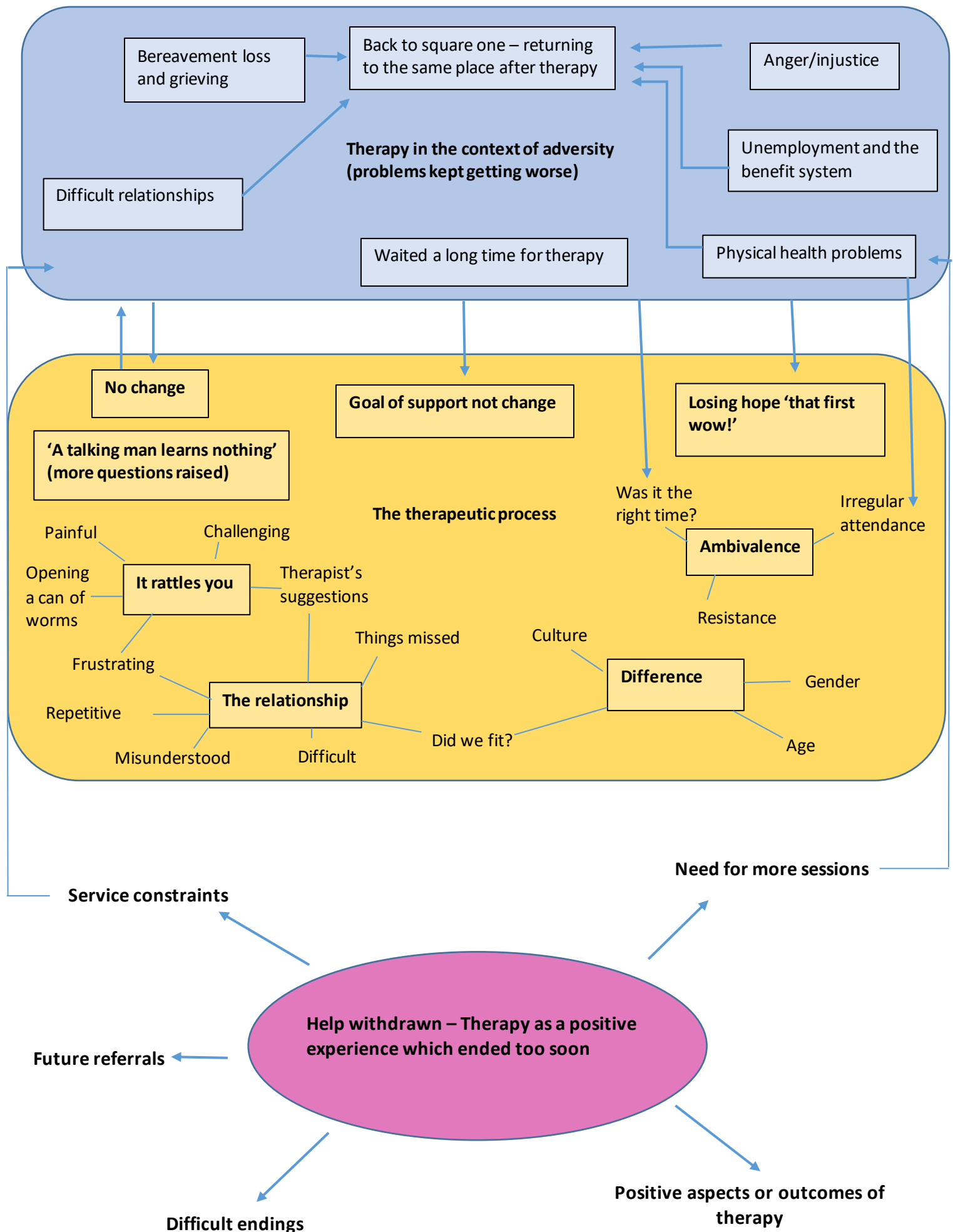


Long-term problems	1, 4, 5, 6, 9, 11
Deviation from CBT protocol	3, 5, 9 (all therapists)
Negative life event	(Included within the context of adversity)
Failure to get feedback from client	5
'Feeling assassinated'/misunderstood	6
Only wanted support not change	6, 8
Obsessive nature	6, 8
Relationship difficulties (outside therapy)	6
Memory problems affecting ability to use therapy	7
Outcome measures – difficult to rate 'what my level of whatever is'	8
Difficult therapeutic relationship	6, 9
More questions raised than answers	10
Time on waiting list meant already feeling better	10
'It rattles you doesn't it' – difficult to talk, draining	1, 4, 8, 10, 11
Accepting vulnerability	10
Therapist suggestions might lead to paranoia	10
'Opening a can of worms' – difficulty with bringing things up from the past	4, 11
Changes take time to sink in	11
Outcome measures focussing on the past and problems instead of future and adaptive functioning	12

Diagram of included themes mapped



An initial Theory of negative change



Appendix 0: Code system and memos

Positive aspects or outcomes	188
1.1 CBT approach fitted	2
1.1.1 CBT was nice/structured	1
1.1.2 Getting back to work - CBT based goals	1
1.2 Mood dropping afterwards	1
1.3 Have made some changes in life	6
1.4 Feeling better	3
1.4.1 Came off medication recently - feel better	3
1.5 Being more active	2
1.5.1 Achieving practical goals	1
1.5.2 Routines with CBT: to keep mood up	2
1.6 Becoming more self-aware	2
1.6.1 Being more aware of difficulties is helpful	5
1.7 Good therapeutic relationship	4
1.7.1 chatting and laughing with the therapist	1
1.8 Learning and applying knowledge	2
1.8.1 The therapist made me realise something important	2
Theory of negative change - help withdrawn	54
1.9.1 Service constraints	2
1.9.1.1 Other clients - similar dilemma	1
1.9.2 Thinking about further input	11
1.9.2.1 Men in sheds	2
1.9.3 Wanted more input	5
1.9.3.1 Happy with CBT but wanted more sessions	1
1.9.3.2 Acceptance that no more help is available	1
1.9.4 Endings	1
1.9.4.1 Mixed feelings at the ending	1
1.10 Outcome measures	0
1.10.1 focussing on past rather than future	1
Theory of negative change - process	161
2.1 challenge of no change	1
2.1.1 Did not look at outcome scores	3
2.2 Ambivalence	0
2.2.1 client didn't know what he wanted	1
2.2.2 was it the right time?	1
2.2.3 Doubt	0

2.2.3.1 Do I have enough will-power for this?	1
2.2.4 'she was alright'	2
2.3 The relationship	0
2.3.1 Failure to get feedback from client	0
2.3.1.1 Being a trainee - talking about therapy experience	1
2.3.2 Frustration	0
2.3.2.1 Never felt angry, maybe frustrated	1
2.3.3 difficult relationship	2
2.3.3.1 Luke-warm relationship with therapist	1
2.3.4 Feeling disappointed	2
2.3.5 I don't think the therapist really understood everything	7
2.3.5.1 Not able to go through with therapist's suggested solution	2
2.4 'That first wow!' The initial boost is not maintained	1
2.4.1 The experience was a bit of a disappointment	1
2.4.2 Therapy lifts mood at the time	3
2.4.3 Homework - doing well or doing badly	2
2.5 'A talking man learns nothing'	1
2.5.1 Needed something more than counselling	1
2.5.2 Don't like talking	0
2.5.2.1 Therapist did well to get me to speak	1
2.5.3 more questions raised than answers	1
2.5.3.1 Therapist asking more questions not advising	3
2.5.4 Too much listening!	1
2.6 Difference	1
2.6.1 It's culture innit	5
2.6.2 Age difference	2
2.7 'It rattles you'	4
2.7.1 Therapist suggestions	3
2.7.2 Painful/difficult subjects	0
2.7.2.1 Talking about difficult things	3
2.7.3 'opening a can of worms'	1
Theory of negative change -Therapy in the context of adversity	149
3.1 Anger	2
3.1.1 Sense of injustice	2
3.1.1.1 an uncertain place	1
3.2 Waited a very long time for therapy	4
3.3 Difficult relationships	2

3.3.1 Family problems/pressure	3
3.3.1.1 family affected	1
3.3.1.2 Looking for work due to family pressure	1
3.3.2 Carer's role	0
3.3.2.1 Advocate work is positive but challenging	1
3.4 Problems kept getting worse	7
3.5 After the session - back to square one	2
3.5.1 stresses and difficulties outside therapy	5
3.5.2 'Back to square one'-living near the problem	1
3.6 Bereavement/loss/grieving	1
3.6.1 no change - deterioration	1
3.6.2 life events - death of family member	6
3.7 Physical health/injury	1
3.7.1 Fertility/pregnancy	4
3.7.2 physical health problem: falling out of good habits	2
3.8 Unemployment/the benefit system	1
3.8.1 losing job - increased need, increased time	1
3.8.2 Being on benefits - calculated to cause depression	4
3.9 Lack of support outside of therapy	0
3.9.1 Difficult just getting there	1
4 Process - deviation from CBT protocol	0
4.1 Incorporating other models	1
4.1.1 Flexible approach - counselling psychology	1
4.1.2 Thinking systemically	2
5 Referral	1
6 Negative change	2
6.1 Learning	1
6.2 Thinking about how to avoid negative change	1
6.2.1 Valued this opportunity to think about case	3
6.3 Political pressures - negative change may result in exclusion	2
7 Client Factors	0
7.1 presenting issues or difficulties	0
7.1.1 Unable to accept feelings	0
7.1.1.1 Accepting depression	1
7.1.2 Depression	4
7.1.2.1 Feeling useless	1
7.1.2.2 How can I help myself out of depression	1

7.1.2.3 The big, vicious cycle of depression	2
7.1.3 working too hard	1
7.2 Interest in psychology	0
7.2.1 Groups/psychology - intrigued by a new thing	1
7.3 supportive family members	2
7.4 Use of medication	0
7.4.1 inconsistent use of medication	1
7.4.2 Medication to help sleep	1
7.5 openness	0
7.5.1 Decision to open up	1

1 Positive aspects or outcomes

1.1.1 CBT was nice/structured

Description of how she found CBT

1.1.2 Getting back to work - CBT based goals

Clients goals as decribed by the therapist, in this case a counselling psychologist. I'm wondering, are they also very male goals? When i phoned this client he did not want to talk about the therapy he received but said 'it wasn't helpful'.

1.2 Mood dropping afterwards

Moods go up and down but although her mood dropped after therapy, it didn't go back to where it was before. This client doesn't actually seem to have come out worse so it's not clear what the outcome measures picked up on.

1.3 Have made some changes in life

The client does not attribute this change to therapy, but nevertheless it seems like it was an important decision or turning point for him

1.4.1 Came off medication recently - feel better

This client decided to stop his anti-depressant medication that he had been taking for a long time. He now feels better than ever. He doesn't attribute this to the therapy but he did stop the medication after the therapy ended.

1.5.1 Achieving practical goals

Not sure, but thinks he found it beneficial, was more active and working towards goals

1.5.2 Routines with CBT: to keep mood up

The benefits of keeping a routine and keeping active, as advocated in CBT - particularly in the treatment of depression which would involve behavioural activation presumably

1.6.1 Being more aware of difficulties is helpful

This client was more aware of her difficulties but described this as a helpful thing. Potentially this

could have caused an increase in symptoms as reported on the outcome measures

1.7.1 chatting and laughing with the therapist

This client was very positive about the therapist she saw, the main theme here is that being able to chat and laugh with the therapist was important and helpful for her

1.8.1 The therapist made me realise something important

In this case the client was feeling very intolerant of others and he was isolating himself. The therapist suggested that the more he isolated himself the more intolerant he would get.

1.9 Theory of negative change - help withdrawn

This includes statements about therapy ending too early, those who requested further input and were denied and negative change as linked to an ending

1.9.1.1 Other clients - similar dilemma

In the context of wanting to give more sessions and the service not allowing this, it not being justified according to improvements or 'making progress'

1.9.2 Thinking about further input

Client was given details of other services, but not referred because the onus was on him to refer

1.9.2.1 Men in sheds

Since therapy ended this client has joined the group 'men in sheds' and was very enthusiastic about it

1.9.3.1 Happy with CBT but wanted more sessions

Particularly in relation to 'chronic depression' this client had clearly discussed with her therapist about having more sessions, but was not provided with any

1.9.3.2 Acceptance that no more help is available

Client describes having to be content with what she has got in relation to having what felt like not enough sessions

1.9.4.1 Mixed feelings at the ending

Therapist mentions carer traumatisation because of the severity of the clients issues and some relief at ending, but also some sadness because they got on well

1.10.1 focussing on past rather than future

this counsellor described that the OMs keep patients focussed on problems and initial presenting issues, rather than looking at their strengths or what they have achieved

2 Theory of negative change - process

My idea is that there may be 3 routes to the negative change as seen on outcome measures, one route is due to problems with the therapeutic process or the type of intervention, one is due to life events or insurmountable circumstances, perhaps including the loss of hope as associated with this and final one, which might be kind of linked to insurmountable circumstances, is 'a good thing withdrawn' or the loss of something which was felt to be useful and valuable, perhaps when this loss felt too soon

2.1.1 Did not look at outcome scores

The therapist describes deliberately not going over the outcome measures because there was no change, although she didn't seem to notice negative change

2.2.1 client didn't know what he wanted

He just wanted something... and things changed over the course of therapy, meaning that the type of intervention may no longer have been suitable

2.2.2 was it the right time?

Looking back the therapist wonders whether in time she will notice these huge events happening around the client, and wonder whether it's not the right time for therapy

2.2.3.1 Do I have enough will-power for this?

Experiences of doubt and hopelessness

2.2.4 'she was alright'

ambivalence towards therapist

2.3.1.1 Being a trainee - talking about therapy experience

This therapist describes how the client was one of the first she saw on placement and so she didn't feel as confident to ask and be open about how the client was finding it

2.3.2.1 Never felt angry, maybe frustrated

Therapist starts talking about her feelings towards the client

2.3.3.1 Luke-warm relationship with therapist

'she was fine' but he didn't go home thinking about what she said

2.3.4 Feeling disappointed

This is the therapist's response to seeing the client's outcome in therapy

2.3.5.1 Not able to go through with therapist's suggested solution

Related to the idea of feeling trapped, the client believes if he tells his girlfriend how he feels, she will kill herself

2.4.1 The experience was a bit of a disappointment

After the initial revelation in the first session, none of the following sessions were as good

2.4.2 Therapy lifts mood at the time

This client describes how therapy works at the time, but when it stops she 'drops back down' into feeling depressed

2.4.3 Homework - doing well or doing badly

Describes homework as a challenge, when she made her goals it was great but when she didn't she felt very despondent

2.5 'A talking man learns nothing'

The therapist was not felt to be giving enough input or advice or the client did not feel it was beneficial to keep talking about problems when there seemed to be no solutions given

2.5.1 Needed something more than counselling

This person was referred for counselling but believes he needed more. I assisted this client to re-refer through his GP because from talking to him it did seem that things were really complicated and he was still quite distressed

2.5.2.1 Therapist did well to get me to speak

This man described how he doesn't really like talking, which may call into question how suitable a talking therapy was for him

2.5.3.1 Therapist asking more questions not advising

Client frustrated that the counsellor wanted him to explain what he needed to do, he seemed at a loss and wanted more suggestions and advice

2.5.4 Too much listening!

Here the client is laughing because earlier he complained about all the talking he did and all the therapist did was listen

2.6.1 It's culture innit

This client is attributing the therapist's approach to her nationality and culture

2.6.2 Age difference

This client mentions talking to a younger woman when I asked about wanting anything to be different. He then goes on to say that it didn't make any difference, why should it. However, I believe that he wouldn't have brought it up if it wasn't an issue to some extent. I believe that maybe he didn't want to complain to me about it, as he saw me as similar.

2.7 'It rattles you'

Therapy brings up issues which are difficult to talk about, clients describe feeling shaken and having difficulty talking or feeling vulnerable when leaving the sessions

2.7.1 Therapist suggestions

The suggestions are not described as helpful in this context

2.7.2.1 Talking about difficult things

The client describes how some conversations would be upsetting, but she does believe that they were necessary and good 'to get it off her chest'

2.7.3 'opening a can of worms'

Talking about past events and dredging up feelings long suppressed or put to one side

3 Theory of negative change -Therapy in the context of adversity

A code which includes negative life events occurring during the course of therapy, subcodes might include 'back to square one' and issues around ESA

3.1.1.1 an uncertain place

court case was still open, no decision, therapist sees therapy as similarly unresolved?

3.2 Waited a very long time for therapy

This client says it took 2-3 years from referral, to be seen by a therapist

3.3 Difficult relationships

Relationships with nannies and a teacher is eluded to

3.3.1.1 family affected

The fact that the client's family were affected by his depression meant that he felt it needed to be fixed urgently

3.3.1.2 Looking for work due to family pressure

The therapist is describing the last session with this client, although they didn't know it would be the last session as the client unexpectedly dropped out.

3.3.2.1 Advocate work is positive but challenging

Client talks more about the voluntary work he does, it's a source of positivity but it may also have been something that made him feel worse during therapy

3.4 Problems kept getting worse

The participant corrects himself in terms of saying nothing got worse. It seems that nothing got worse due to the therapy but there were problems around him that were always getting worse

3.5.1 stresses and difficulties outside therapy

Therapist describes situation where client was insulted/mockered about his amputated fingers

3.5.2 'Back to square one'-living near the problem

This client is still very distressed about events surrounding his divorce and his ex-wife and children live very close to him now so he will still potentially see them

3.6 Bereavement/loss/grieving

This includes death of family members, loss through divorce and also loss of body/self. It seems like they may be implicated in an explanation of why the therapy couldn't really work at that time or why the person was feeling so bad - or ended up feeling worse

3.6.1 no change - deterioration

The clients mood may have got worse due to bereavement

3.6.2 life events - death of family member

this client's mother-in-law went into a hospice after her first session of CBT and later passed away. Although the client came back afterwards, this seemed to significantly disrupt the therapy

3.7.1 Fertility/pregnancy

It sounds like she approached the GP because she anticipated depression rather than actually

experiencing it at that time, and was judged to be high risk because of her pregnancy

3.7.2 physical health problem: falling out of good habits

Knee operation puts an end to the behavioural activation plan

3.8 Unemployment/the benefit system

A subcode of the category - External problems

3.8.1 losing job - increased need, increased time

Client wasn't sure that therapy would work and didn't have the time before anyway. After losing her job she felt worse but also had 'all the time'.

3.8.2 Being on benefits - calculated to cause depression

A description of applying for benefits, not getting appointments, not getting the money you need, not getting informed about decisions made etc

3.9.1 Difficult just getting there

This section includes issues around travelling and money

4 Process - deviation from CBT protocol

4.1.1 Flexible approach - counselling psychology

It's not clear to me in this passage what approach the therapist is stating that they used. It interests me as well that she says his goals were very CBT based, but they didn't do 'all the kind of CBT'. I think I also need to be aware that I may be trying to find fault with the therapist though, particularly as this therapist had more than one client who had deteriorated according to outcome measures in the past year

4.1.2 Thinking systemically

The therapist thinks about this in retrospect, whether it would have been a helpful way to work

5 Referral

Major category to indicate responses around the reasons for referral - what led to you seeking help?

6.2.1 Valued this opportunity to think about case

Therapist describes how the process of this interview was useful and that there is not enough time in IAPT for these reflective spaces

6.3 Political pressures - negative change may result in exclusion

This is a possible problem with investigating negative change in the context of an IAPT service which has clear financial drivers

7 Client Factors

7.1.1.1 Accepting depression

Cannot accept the way he feels - psychoeducation to normalise and learn about depression

7.1.2.1 Feeling useless

The client is trying to push himself forward, but there is a voice inside telling him he can't do it

7.1.2.2 How can I help myself out of depression

The client responds to a question around what she wanted help with

7.1.2.3 The big, vicious cycle of depression

Here the client describes the symptoms she had and how she wanted help to break out of the vicious cycle

7.1.3 working too hard

Working all the time, perhaps too hard, but this client seems to partly blame his divorce on all of his working

7.2.1 Groups/psychology - intrigued by a new thing

Client sounds interested and perhaps hopeful, she is responding to a question around group therapy however she talks about psychology as a whole so presumably found the whole idea of therapy intriguing

7.3 supportive family members

The client describes having supportive parents, both financially and emotionally, however she seems ambivalent seems to be saying that financial security meant she didn't have such a drive to 'exist in the real world'

7.4.1 inconsistent use of medication

When he feels better he will stop taking the tablets

7.4.2 Medication to help sleep

Client is describing initial help from GP, medication which didn't seem to work at all on a lower dose, helps him to sleep sometimes, but not always

7.5.1 Decision to open up

Client says he had been holding everything in from an early age and didn't want to talk but decided the time had come, he had to

Appendix P: End of study declaration form

DECLARATION OF THE END OF A STUDY

(For all studies except clinical trials of investigational medicinal products)

To be completed in typescript by the Chief Investigator and submitted to the Research Ethics Committee (REC) that gave a favourable opinion of the research within 90 days of the conclusion of the study or within 15 days of early termination.

For questions with Yes/No options please indicate answer in bold type.

1. Details of Chief Investigator

Name:	Christina Hart
Address:	*****
Telephone:	*****
Email:	c.m.hart509@canterbury.ac.uk
Fax:	

2. Details of study

Full title of study:	<u>A qualitative analysis of the experience of change following therapy</u>
Research sponsor:	Salomons Centre for Applied Psychology, Canterbury Christchurch University
Name of REC:	Nres committee London-Dulwich
REC reference number:	15/LO/0027

3. Study duration

Date study commenced:	05/06/2015
Date study ended:	30/03/2016
Did this study terminate prematurely?	No If yes, please complete sections 4, 5, 6, & 7. If no, please go direct to section 8.

4. Recruitment

Number of participants recruited	12
----------------------------------	-----------

Proposed number of participants to be recruited at the start of the study	12
If different, please state the reason or this	

5. Circumstances of early termination

What is the justification for this early termination?	
---	--

6. Temporary halt

Is this a temporary halt to the study?	No
If yes, what is the justification for temporarily halting the study? When do you expect the study to re-start?	e.g. Safety, difficulties recruiting participants, trial has not commenced, other reasons.


7. Potential implications for research participants

Are there any potential implications for research participants as a result of terminating/halting the study prematurely? Please describe the steps taken to address them.	
--	--

8. Final report on the research

Is a summary of the final report on the research enclosed with this form?	Yes If no, please forward within 12 months of the end of the study.
---	--

9. Declaration

Signature of Chief Investigator:	
Print name:	Christina Hart
Date of submission:	23/04/2016

Appendix Q: Final report for ethics

A qualitative analysis of the experience of change following therapy: Final report

This study aimed to generate a theory of negative change by interviewing 12 clients and therapists about their experience of therapy when reliable score deterioration on outcome measures had been observed. This aim was achieved and in-depth interviews were conducted with eight clients and four therapists about their experience of the process of therapy.

The interviews were transcribed, then coded using the MAX-QDA programme. The initial five interviews were coded on a line by line basis before an initial code system was developed. This code system was then revised using diagramming to search for hypotheses in the data and coding was revisited according to this system. Coding was validated by calculating inter-rater agreement. The final model was also revised following feedback from supervisors and a Grounded Theory expert. The principal researcher aimed for reflexivity by taking part in a bracketing interview before recruitment took place, writing memos and keeping a research diary throughout the study period.

The emerging Grounded Theory model identified three main themes which helped to explain negative change as experienced by this sample; Therapy in the context of adversity, negative change related to therapeutic process and positive input which may have been withdrawn too soon.

The findings highlighted the importance of paying attention to context and life events in negative change. Many clients wanted further input and some did not think there had been a negative outcome, or noted that change was not instant. Varied process issues highlighted the need to adjust interventions to fit clients.

An edited paper of this study will be submitted to the journal 'Psychotherapy Research'

Participants were offered the opportunity to attend feedback groups but those who wanted feedback indicated that they would prefer to receive emails detailing the main findings.

Since therapists and clients were given slightly different information regarding the study aims a separate email/letter was sent, please see attached for details.



A qualitative analysis of the experience of change following therapy

Dear ----,

Thank you for your recent participation in the above study. Your input has been very much valued and appreciated. This study aimed to find out more about your experience of short term therapy, and what factors might play a part in its effectiveness. In order to keep an open mind and not influence your feedback, we did not emphasise our particular interest in any negative outcomes. This is because these outcomes are currently not well researched, and because information about them could be very helpful in improving the quality of services that are offered.

However, we found that most people had a positive experience of therapy and were appreciative of the IAPT service and what it offers. There were many positive outcomes which people spoke about. Negative experiences could often be linked to life events outside of therapy or sometimes to feelings that therapy had ended too soon. Negative experiences which were not linked to these factors included;

- Feeling that the therapy involved too much listening by the therapist, without many solutions offered
- Feeling that the therapy was sometimes difficult, in terms of bringing up past experiences or talking about upsetting topics
- Having a difficult relationship with the therapist
- Feeling quite different to the therapist
- Feeling like it might not be the right time to make change

As indicated above, the results of this study are useful to help services think about how they might be able to improve.

If you would like any further information about the study's results, you may recall from the initial information sheet I provided that it is our intention to publish them in an academic journal (all quotes will be fully anonymised). Please let me know by email if you would like to be sent a copy of this.

Thank you again for your time,

Yours sincerely,

Christina Hart

Trainee Clinical Psychologist

C.M.Hart509@canterbury.ac.uk



A qualitative analysis of the experience of change following therapy

Dear ----,

Thank you for your recent participation in the above study. Your input has been very much valued and appreciated. This study aimed to find out more about the experience of negative change following short term therapy, and what factors might be associated with this. Negative outcomes are currently not well researched, and information about them could be helpful in improving the quality of services that are offered.

However, we found that most people had a positive experience of therapy and were appreciative of the IAPT service and what it offers. There were many positive outcomes which people spoke about. Alternatively, negative experiences could often be linked to life events outside of therapy or sometimes to feelings that therapy had ended before the client was ready. Negative experiences which were not linked to these factors included;

- Feeling that the therapy involved too much listening by the therapist, without many solutions offered
- Feeling that the therapy was sometimes difficult, in terms of bringing up past experiences or talking about upsetting topics
- Having a difficult relationship with the therapist
- Feeling quite different to the therapist
- Feeling like it might not be the right time to make change

If you would like any further information about the study's results, you may recall from the initial information sheet I provided that it is our intention to publish them in an academic journal (all quotes will be fully anonymised). Please let me know by email if you would like to be sent a copy of this.

Thank you again for your time,

Yours sincerely,

Christina Hart

Trainee Clinical Psychologist

C.M.Hart509@canterbury.ac.uk

Appendix T: Author guideline notes for chosen journal

Psychotherapy Research



Published in association with the Society for Psychotherapy Research

ISSN

1050-3307 (Print), 1468-4381 (Online)

Publication Frequency

6 issues per year

Instructions for authors

Thank you for choosing to submit your paper to us. These instructions will ensure we have everything required so your paper can move through peer review, production and publication smoothly. Please take the time to read them and follow the instructions as closely as possible.

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Manuscript preparation

1. General guidelines

- Manuscripts are accepted in English (for non-English submissions see Manuscript submission section below). Oxford English Dictionary or US spelling are preferred. Please use double quotation marks, except where "a quotation is 'within' a quotation". Long quotations of 40 words or more should be indented without quotation marks.
- There is no word limit for articles but authors should include a word count with their manuscript.
- Manuscripts should be compiled in the following order: title page (including Acknowledgements as well as Funding and grant-awarding bodies); abstract; keywords; main text; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figure caption(s) (as a list).
Please supply all details required by any funding and grant-awarding bodies as an acknowledgement in a separate Funding paragraph as follows:
For single agency grants
This work was supported by the <Funding Agency> under Grant <number xxxx>.
For multiple agency grants
This work was supported by the <Funding Agency #1> under Grant <number xxxx>; <Funding Agency #2> under Grant <number xxxx>; and <Funding Agency #3> under Grant <number xxxx>.
- [Abstracts](#) of 100-200 words are required for all manuscripts submitted. The abstract should be structured with the following headings: **Objective, Method, Results, Conclusions.**
- Each manuscript should have 5 to 6 [keywords](#).
- Search engine optimization (SEO) is a means of making your article more visible to anyone who might be looking for it. Please consult our guidance [here](#).
- Section headings should be concise.
- All authors of a manuscript should include their full names, affiliations, postal addresses, telephone numbers and email addresses on the cover page of the manuscript. One author should be identified as the corresponding author. Please give the affiliation where the research was conducted. If any of the named co-authors moves affiliation during the peer review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after the manuscript is accepted. Please note that the email address of the corresponding author will normally be displayed in the article PDF (depending on the journal style) and the online article.
- All persons who have a reasonable claim to authorship must be named in the manuscript as co-authors; the corresponding author must be authorized by all co-authors to act as an agent on their behalf in all matters pertaining to publication of the manuscript, and the order of names should be agreed by all authors.
- Biographical notes on contributors are not required for this journal.
- Authors must also incorporate a [Disclosure Statement](#) which will acknowledge any financial interest or benefit they have arising from the direct applications of their research.
- For all manuscripts non-discriminatory language is mandatory. Sexist or racist terms must not be used.
- Authors must adhere to [SI units](#). Units are not italicised.
- When using a word which is or is asserted to be a proprietary term or trade mark, authors must use the symbol ® or TM.
- Authors must not embed equations or image files within their manuscript.

Informed consent and anonymity

- Manuscripts must include a statement that informed consent was obtained from human subjects. Ethical and legal considerations require careful attention to the protection of a patient's anonymity in case reports and elsewhere. Identifying information such as names, initials, hospital numbers, and dates must be avoided. In addition, authors should disguise identifying information about the characteristics and personal history of patients. Manuscripts that report the results of experimental investigations with human subjects must include a statement that informed consent was obtained after the procedure(s) had been fully explained. Where children are involved, authors are asked to include information about whether assent was also obtained from the child's legal guardian

Code of experimental ethics and practice and confidentiality

- Contributors are required to follow the procedures in force in their countries which govern the ethics of work conducted with human or animal subjects. The Code of Ethics of the World Medical Association (Declaration of Helsinki) represents a minimal requirement.
- For human subjects or patients, describe their characteristics. For human participants in a research survey, secure the consent for data and other material - verbatim quotations from interviews, etc. - to be used. Specific permission for any facial photographs is required. A letter of consent must accompany any photographs in which the possibility of identification exists. It is not sufficient to cover the eyes to mask identity.
- It is your responsibility to ensure that the confidentiality of patients is maintained. All clinical material used in your article must be disguised so that it is not recognisable by a third party. Where possible and appropriate, the permission of the patient should be obtained. Authors are invited to discuss these matters with the editor if they wish.

2. Style guidelines

- [Advice to authors on preparing a manuscript](#)
- [Description of the Journal's reference style.](#)
- An [EndNote output style](#) is available for this journal.
- [Guide to using mathematical scripts and equations.](#)
- [Word templates](#) are available for this journal. If you are not able to use the template via the links or if you have any other template queries, please contact authortemplate@tandf.co.uk.

3. Figures

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